J26220 SO7101

A qualitative exploration of therapists' experience of working therapeutically pre-trial within the Crown Prosecution Service guidelines with adult clients who have reported sexual violence

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Dissertation submitted to the University of Chester for the Degree of Master of Science (Psychological Trauma) in part fulfilment of the Modular Programme in Psychological Trauma

January 2019

Declaration

This work is original and has not been submitted previously in support of any qualification or course.

Signed: 

Name: Madelyn Nixon

Acknowledgements

I would like to acknowledge and thank my dissertation supervisor, Nikki Kiyimba, whose support and guidance throughout this process has been invaluable.

I would also like to thank my research participants for their openness, honesty and willingness to share their experiences with me and without whom this study would not have been possible.

Finally, I would like to thank my husband, my children and my friends for their enduring encouragement, support and patience they have given me whilst completing this research project.

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i) List of abbreviations

BACP	British Association for Counselling and Psychotherapy
BPS	British Psychological Society
CJS	Criminal Justice System
CPS	Crown Prosecution Service
EMDR	Eye Movement Desensitisation and Reprocessing
IPA	Interpretative Phenomenological Analysis
ISVAs	Independent Sexual Violence Advocates
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office of National Statistics
PTSD	Post-Traumatic Stress Disorder
PTT	Pre-Trial Therapy
SARCS	Sexual Assault Referral Centres
TF-CBT	Trauma-Focused Cognitive Behavioural Therapy

ii) Tables and diagrams

iii) Individual chapters with titles

Abstract

This research is one of the first qualitative studies to explore the lived experience of therapists who were working pre-trial, within the Crown Prosecution Service guidelines with adult clients who had reported sexual assault. The aim of the study was to obtain a detailed account of the therapists' experience in order to acquire a deeper understanding of how the participants created meaning from their practice. Interpretive Phenomenological Analysis was chosen as an appropriate approach to analyse the data gathered. Semi-structured interviews took place with six therapists. Upon analysis five super-ordinate themes emerged which were, i) the differences between pre-trial therapy and generic therapy, ii) the psychological impact of working with this client group, iii) the complexity of the work, and competency of the therapists, iv) the dilemmas and conflicts inherent in the work, and v) an expression of a loss of faith in the Criminal Justice System. These findings illustrated the complexities that therapists are faced with when working with clients' pre-trial. A discussion is provided relating to the extensive research that has been carried out since the Crown Prosecution Service (CPS) guidelines were written in 2001 into the fallibility of memory following a traumatic incident, and the developments that have taken place in therapeutic techniques. In light of recent research and developments in therapy, it is suggested that there is potentially an argument for the need for a review and update into the current CPS guidelines into the provision of therapy for vulnerable or intimidated adults prior to trial. It is also recommended that further research is needed into whether the fallibility of memory following a traumatic incident improves after the person has undertaken an appropriate evidence-based trauma-specific treatment, and the possible need for a central register of therapists that are qualified to offer pre-trial therapy.

Chapter 1

Literature Review

Introduction

According to the Office for National Statistics (ONS, 2018) the recorded sexual offences by the police rose to 154,162 in the United Kingdom (UK) for the year ending June 2018, which was an increase of 18% from the previous year. Some factors that may have contributed to the rise in recorded sexual assaults were the improvement in the police recording of the crime and the increased social media campaigns and high-profile coverage of sexual offences which may have led to more victims coming forward to report these crimes (ONS, 2018).

The Crown Prosecution Service, 'Violence Against Women and Girls' crime report reported that in the UK *"108 more defendants were convicted of rape in 2015-16 than in 2014-15"* (CPS, 2015-16, p46). However, the conviction rate for reported rape cases was as low as 7% in the UK according to the Ministry of Justice, Home Office and the Office of National Statistics (2013), which was the lowest conviction rate for rape in Europe. This highlights the apparent need for progression in this area in the UK (Hohl and Stanko, 2015; Lovett and Kelly, 2009).

The National Health Service England (NHS England, 2018) stated that up to 80% of sexual assaults are not reported, and only 28% of victims will go to the police to report the crime. Furthermore, male sexual assault is known to be an under-reported crime worldwide (NHS England, 2018). Due to the high number of victims that do not report the offence, whether that was due to fear or lack of faith in the Criminal Justice System (CJS), NHS England (2018) developed partnerships with the Home Office,

Ministry of Justice and the local police and Crime Commissioners to look at how they could address the problem and offer support to the victims of sexual assault and abuse. In April 2013, NHS England worked together with the Police and Crime Commissioners to take on the commissioning role for Sexual Assault Referral Centres (SARCS). The SARCS offer a safe environment 24 hours a day, 365 days of the year, where victims of sexual assault can receive immediate help and support, whether they choose to report the crime to the police or not. They have access to a forensic medical examination, medical support and advice, ongoing support from Independent Sexual Violence Advocates (ISVAs) and the opportunity to speak to a counsellor/therapist (NHS England, 2018). NHS England (2018) are the lead commissioners and are responsible for supporting 47 SARCS across England. Due to a growth in demand for these services in 2015/16 the investment in the services have been increased (NHS England, 2018).

The SARCS offer specialist therapy for those victims who have either been referred by the police, another organisation or have self-referred. The therapists working within an organisation that deals predominantly with sexual assault, are likely to have knowledge of the Crown Prosecution Service guidelines (CPS, 2001) and possibly have been provided with training in pre-trial therapy. The organisations themselves are set up to deal with this particular area of therapy (NHS England, 2018).

However, in private practice there may not be an inducement to become aware of the CPS guidelines, and how the guidelines may be pertinent to the work with a client who was pre-trial. On an initial search of the British Association for Counselling and Psychotherapy (BACP) 'Find a Therapist' website, there were a number of therapists that advertised they work with sexual assault, but that didn't specifically state that they were trained in pre-trial therapy. The question could be asked as to how many therapists in private practice are aware of the CPS guidelines and the differences

between generic counselling and pre-trial therapy? This may be particularly significant due to the rise in victims coming forward for help following the social media campaigns and more recent allegations against well-known personalities in Hollywood, which may also result in an increase in the number of victims accessing private therapy (ONS, 2018).

Overview of Literature Search

The literature search unveiled information suggesting that a high percentage of people who have been raped or sexually assaulted go on to develop Post-Traumatic Stress Disorder PTSD (Rothbaum, Foa, Riggs, Murdock and Walsh, 1992; Smith and Heke, 2010). Therefore the reach of the literature review was also extended to include both the recommendations of the CPS guidelines in relation to pre-trial therapy for victims of sexual assault (CPS, 2001) and also the National Institute for Health and Care Excellence (NICE, 2005) recommendations in relation to the treatment of PTSD (DSM-5, 2013). Further searches also uncovered information on pre-trial therapy and legal issues relating to therapists in this area.

Also, there was a survey (a service evaluation under NHS trust policies of 35 practitioners who attended a conference on pre-trial therapy (PTT) in 2014) which was carried out by counsellors at St Mary's Sexual Assault Referral Centre (SARC) attempting to learn about practitioners views and experiences of pre-trial therapy (Jenkins, Muccio and Paris, 2015). All of this information formed the starting point for the literature review and are examined in more detail herein.

Literature Search Strategy

A keyword search method was identified as a suitable way to discover relevant literature. Highlighting the most significant keywords, different spellings were used together with alternative terms to extensively capture pertinent information (Younger, 2004). This is an approach to ensure appropriate literature was formulated by using Boolean Operators to link the keywords together (Hart, 2001). The following formulations were used:

- (Psychotherapy OR Counseling OR Counselling OR Therapy OR Psychology) AND (Sexual Assault OR Sexual Abuse OR Rape OR Sexual Violence);
- (Pre-Trial Therapy OR PTT) AND (Sexual Assault OR Sexual Abuse OR Rape OR Sexual Violence);
- (CPS OR Crown Prosecution Service OR Criminal Justice System) AND (Psychotherapy OR Counseling OR Counselling OR Therapy OR Psychology)
- (CPS OR Crown Prosecution Service OR Criminal Justice System) AND (Sexual Assault OR Sexual Abuse OR Rape OR Sexual Violence).

An extensive search was carried out by resources provided by Chester University library, including: Chesterrep; OpenAthens; PsycINFO; PscyNET; PscyBOOKS; socINDEX; CINAHL; Wiley Online Library and an electronic search of online databases included: Healthcare Counselling and Psychotherapy Journal; The British Journal of Criminology; European Journal of Criminology; Sage Journals; BACP; BPS; and internet sites Google and Google Scholar. Material from the researcher's personal library were also utilised.

Following an exhaustive literature search, contact was also made with a leading author in the field (Peter Jenkins), who provided links to further articles, a DVD on a

relevant conference and contact information of other colleagues who had expertise in the field.

The Crown Prosecution Service (CPS) Guidelines

In 2001 the Home Office, the Department of Health and the Crown Prosecution Service (CPS) joined together to produce a practical guide, primarily aimed to assist therapists when providing therapeutic interventions to vulnerable or intimidated witnesses pre-trial (CPS, 2001).

The CPS' (2001) definition of vulnerable adult is a person who has a learning disability, mental disorder or a physical disability that may impact their ability to give evidence. An intimidated witness is described as possibly having diminished capability of providing best evidence due to their distress or fear (CPS, 2001).

The CPS guidelines acknowledge that vulnerable or intimidated adults should not be denied the opportunity of receiving therapeutic support that may assist them in providing a better quality of evidence, however, clear recommendations as to what could be covered in the therapy sessions were set out (CPS, 2001; Rogers, 2003).

The recommendations for therapeutic work undertaken pre-trial in the CPS guidelines included the following:

- The client should have completed a best evidence statement with the police before therapy commences.
- The police and CPS need to be notified if therapy is taking place or is planned to take place.

- Therapy should focus on supporting the witness with the emotional impact of the incident, improving their confidence and self-esteem and preparing the witness for court.
- The witness should not discuss any of the evidence relating to the criminal proceedings, if such discussions take place, this may lead to allegations of coaching and the criminal case could fail as a result. Coaching in relation to the CPS guidelines is deemed as discussions with the witness of questions and answers that may form part of the criminal proceedings.
- There is a possibility that the therapist working with a client pre-trial, may be called to court as a witness themselves.
- Confidentiality cannot be guaranteed, as records of therapy are likely to be summoned by the courts (CPS, 2001).

The guidelines state that ‘some forms of therapy may undermine the evidence’ such as recounting or re-enactment of the offence, and recommend cognitive behavioural techniques as preferable to other therapeutic approaches. However, the guidelines also state that it will not automatically be the case that therapy would undermine the evidence. They suggest that advice may be given on an individual basis as to the impact of the therapy received on the evidence of the witness (CPS, 2001).

The CPS (2001) guidelines acknowledge that whether therapy takes place is not, ultimately, the decision of the CPS or the police, but such a decision will lie with the witness and the professional providing the service. The guidance only specifies that consideration of therapeutic involvement needs to be in the best interest of the witness. However, there is also the caveat that considering the wellbeing of the witness may result in the abandonment of the criminal proceedings (CPS, 2001). The guidance recommends psychotherapy as a treatment for an adult who has been

deeply traumatised and has post-traumatic stress disorder (PTSD) and describes psychotherapy as a treatment plan to reduce distress, maladaptive behaviour and psychological symptoms, and so improve personal interaction and functioning (CPS, 2001). Notably, however, the CPS guidelines were produced in 2001, which is prior to the National Institute for Health and Care Excellence (NICE) guidelines, which were written in 2005. The NICE (2005) guidelines set out recommended treatments for PTSD as shown below.

The National Institute for Health and Care Excellence (NICE) Guidelines

The key symptoms of Post-Traumatic Stress Disorder (PTSD) are: re-experiencing of traumatic event; hyperarousal / hypervigilance; avoidance of any reminders associated with the incident and negative changes in thoughts and moods (DSM-5, 2013; NICE, 2005). Further symptoms associated with PTSD are fear, shame and dissociation (Andrews, Brewin, Rose and Kirk, 2000; Foa and Rothbaum, 1998; Talbot, Talbot, and Tu, 2004).

The National Institute for Health and Care Excellence (NICE, 2005) recommend that a person presenting with PTSD symptoms for more than three months following a trauma should be offered either Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) as evidence based treatments for PTSD. Furthermore, NICE (2005) state that trauma-focused psychological treatments are the required treatment for PTSD and non-directive therapies that do not address the trauma memories should not normally be offered.

Due to the psychological consequences of sexual assault and rape, it is reported that 60 – 65% of victims will go on to develop PTSD (Rothbaum et al. 1992; Smith and Heke, 2010). The treatments for PTSD as recommended by NICE (2005) are TF-

CBT and EMDR, both of which may be seen as recounting of the traumatic incident, although that is not necessarily a requirement of EMDR, but according to the CPS (2001) guidelines they may be perceived as coaching and therefore, would almost certainly lead to the failure of the trial (Foa, Hembree and Rothbaum, 2007; Shapiro, 2001). Smith and Heke (2010) believed that the discrepancies between the CPS guidelines and the NICE guidelines created a dilemma for the client and the therapist as to whether to follow the CPS guidelines and not jeopardise the criminal proceedings, or whether the well-being of the client comes first and the symptoms of PTSD are treated. The British Association for Counselling and Psychotherapy (BACP, 2018) state in their ethical framework that the ethical commitments that underpin the work with a client are to alleviate symptoms of distress and suffering, and to enhance their wellbeing and autonomy. Thus, those therapists governed by this ethical framework may further be conflicted between their ethical priorities and the legal implications.

Legal Issues and Therapeutic Practice

Bond and Sandhu (2005) reported on the difficulty experienced by therapists who were exposed to the court environment that had different ethical priorities to their professional priorities. When working with a client who may become a witness in court, the therapist then had to be mindful of the court proceedings and avoid ‘contaminating’ witness evidence (Bond and Sandhu, 2005). When defence are made aware that therapy had taken place, they may focus on this as an attempt to undermine the evidence with possible allegations of coaching (Bond and Sandhu, 2005). This is why it is important for the therapist to have confidence in their knowledge of the court proceedings and recording of session notes, and competence

in their therapeutic interaction with the client (Bond and Sandhu, 2005). Not only might therapy notes be subpoenaed, it is possible that the therapist may also be called as a witness (Bond and Sandhu, 2005). James Hamilton, a defence and prosecution barrister in sexual assault cases, stated in a PTT conference, that "*all therapists that are working pre-trial should think of themselves as potential witnesses"* (Hamilton, 2014).

Working in the field of sexual assault involves a multitude of issues, ethical, professional and legal, which the therapist needs to be aware of and judge whether they are competent to deal with (Bell-Boule and Roche, 2002). Competency is an ethical requirement under both the BACP (2018) Ethical Framework and The British Psychological Society (BPS, 2018) Code of Ethics and Conduct. The CPS (2001) state that therapists working with vulnerable or intimidated adult witnesses should be appropriately trained and supervised and have a good understanding of the guidelines prior to a criminal trial. Williams (2002) referred to the criminal justice systems struggle to differentiate between 'coaching' and therapy. This may partially account for why therapists report that the police are still frequently informing witnesses that they are not allowed PTT, even though the CPS (2001) guidelines clearly state that is not the case (Jenkins, 2013). One explanation might be that the police receive limited training in mental health (McLeod, Philpin, Sweeting, and Evans, 2010). Furthermore, Maddox, Lee and Barker (2011) state the symptoms of PTSD such as dissociation (numbness), may lead the police to question the truthfulness of the witnesses' disclosure. It has been argued that in many places in the UK, the police are not trained in understanding the psychological consequences of rape and sexual assault, the apparent lack of distress displayed by a witness suffering from dissociation may result in them not being believed and the police not empathising with the victim (Maddox et al. 2011). This lack of training and concern

over the court case being jeopardised by PTT can have devastating results to the witness as shown below.

Complexities of Pre-Trial Therapy

The research carried out by counsellors at St Mary's Sexual Assault Referral Centre took the form of a survey of questions that were asked of the 35 practitioners who attended a pre-trial therapy conference relating to their experiences of working pre-trial (Jenkins et al. 2015). The results disclosed a series of complexities the therapists reported in relation to ethical, therapeutic and legal dilemmas when involved in PTT and highlighted the lack of research into the experiences of therapists in this area of work (Jenkins et al. 2015). The concern associated with PTT contaminating the evidence of a witness and jeopardising the outcome of the trial has led to some witnesses being denied the opportunity of receiving therapy prior to the conclusion of the criminal proceedings (Rogers, 2003). Herman (2003) explained how criminal proceedings could distress the most robust person, and for those who may be experiencing symptoms of PTSD, the justice system could be described as a 're-victimization'.

The case of Frances Andrade, a witness in the criminal trial over indecent assault allegations against her former music teacher, received media attention, as Frances was wrongly informed that she could not receive therapy prior to the court proceedings (Barrett, 2013). Frances described the cross-examination process to a friend, as feeling like she was being 'raped all over again', and she took a fatal overdose a few days after giving evidence (Barrett, 2013). There was a subsequent serious case review by Professor Hilary Brown who concluded that criminal justice systems needed to improve their practice in supporting witnesses in sexual abuse

trials and the police should be promoting PTT (Jenkins et al. 2015). McLeod et al. (2010) reported that counselling prior to the criminal trial has shown to assist witnesses' in their recovery from the traumatic event and help with their distress during the court procedure that had led to healthier management when giving evidence. Despite these findings and the CPS (2001) guidelines stating that it is not a decision for the CPS or the police as to whether a witness received therapy, therapists working in this field are still reporting that in some cases clients have been told by the police they cannot have PTT (Barratt, 2013).

Summary

The literature search uncovered some key areas that may present challenges for therapists when providing PTT. The CPS (2001) guidelines gave a practical framework for therapists providing therapeutic interventions, however, there is an ambiguity as to their recommendations and how advice may be different depending on individual cases. The CPS (2001) guidelines also state that the wellbeing of the client is paramount, but putting the client's wellbeing first, could jeopardise the outcome of the trial. Arguably, NICE (2005) recommend a treatment programme for PTSD that conflicts with the current CPS (2001) guidelines. Bond and Sandhu (2005) also highlighted a number of legal issues raised for therapists when working in the court environment and Bell-Boule and Roche (2002) emphasised the plethora of issues faced by the therapists working in this field, such as; ethical dilemmas, knowledge and competency. Amid all of this, the evidence supporting the value of PTT and the role of the therapist working with a client who has suffered psychological trauma has not always been fully recognised by the criminal justice system (Barratt 2013; McLeod et al. 2010).

Research Aims and Objectives

Taking into consideration the complexities the therapist working in this field is presented with, it is perhaps surprising that there is limited research into how this is experienced by the practitioner. This study, therefore, aimed to explore the lived experience of therapists who have worked pre-trial with adult clients who reported sexual assault in accordance with the CPS guidelines. The objectives were to gain an understanding of the challenges that may occur, and how their experience may assist other therapists working in this area and provide guidance when producing or revising existing policy. The material gathered in the literature search provided the areas in which key issues arose and formed the basis of the questions asked in the semi-structured interviews.

Chapter 2

Methodology and Methods

Research Philosophy and Design

The research question, ‘what is the lived experience of therapists who are working pre-trial within the CPS guidelines with adult clients who have reported sexual abuse’ lends itself to a qualitative methodology as there was not a pre-existing hypotheses that was being tested, but the intention was to explore and understand the meaning of the lived experience of the participants (Braun and Clarke, 2013; Cresswell, 2014; McLeod, 2011). Qualitative research focuses on spoken language and aims to obtain detailed accounts from participants in order to gather informative and rich data, rather than collecting numbers and scientific data that is used more regularly in quantitative research (Braun and Clarke, 2013).

A critical realist position was adopted to address this research project and the methodology of Interpretive Phenomenological Analysis (IPA) was congruent with this epistemology (O’Reilly and Parker, 2014). IPA is an inductive approach that explores how individuals make sense of their experiences and the philosophical principle of the approach is phenomenological (Reid, Flowers, and Larkin, 2004; Smith, Flowers, and Larkin, 2009). The study used IPA as an appropriate approach as the methodology lends itself to an in depth examination into the participants experience, and encourages the participants to reflect on what was happening for them. This process is part of an attempt to establish the subjective meaning of the event to the individual (Smith et al. 2009).

The methodology of IPA is also compatible with the view taken by Carl Rogers' Person Centred Therapy, which proposes that, no matter how strange it may seem, the therapist validates the clients reported current experience as genuine and explores them with the client as such (Coolican, 2013). This research explored how the therapists interviewed, worked with their clients in that way, and how that may have impacted them and how they made sense of their experience.

What makes IPA different from other qualitative approaches is that there are three key elements; phenomenology (Husserl, 1927), hermeneutics (Heidegger, 1962) and idiography (Smith et al. 2009). Husserl (1927) described phenomenology as how an individual could accurately decipher their particular experience of a situation and believed this involved reflexivity (Smith et al. 2009). For this research project, this was important when exploring the thoughts, feelings and reflections of the participants, and for examining their sense making of what was happening in the therapeutic process. Husserl used the term 'intentionality' to describe the process of consciously focusing on what has been experienced and in order to do this he suggested the person 'bracket' (set aside) pre-conceived judgements of the world (Smith et al. 2009). Husserl's work has informed this project by recognising the importance of reflection when trying to establish the subjective experience of the individual (Smith et al. 2009).

The idiographic element of IPA differs to most psychology as it focuses on individual cases, rather than a nomothetic approach that looks to determine general 'laws' that are shared between groups of individuals (Smith et al. 2009; Smith and Osborne, 2004). The idiographic approach leads to in-depth and detailed analysis of the individual case before moving to more general accounts of what is shared (Smith et al. 2009; Smith and Osborne, 2004). However, this does not mean idiography

eschews generalisations, but ascertains the generalisations in a different format (Smith et al. 2009; Smith and Osborne, 2004). The idiographic component of IPA enabled a detailed examination of the therapists' experience of working within the Crown Prosecution Service (CPS) guidelines with adult clients who had been sexually assaulted pre-trial and what that was like for them.

Heidegger (1962) explored the theory of hermeneutics (interpretation) and stated that the interpreter will bring their own fore-conceptions (assumptions, life experiences, preconceptions) when presented with an encounter (Smith et al. 2009). He suggested this can present an obstruction to interpretation and so contrary to Husserl's idea of bracketing, he believed this was something that could only be partially achieved (Smith et al. 2009). Therefore, the IPA researcher not only deals with the process of double hermeneutics, making sense of meaning of the participants meaning of their world, but they also need to be aware of their own fore-conceptions that they are bringing to the experience (Smith and Osborn, 2004). This required a reflexive practice throughout the research study, critically examining what may be the researcher's own fore-conceptions and bracketing where possible. In addition, this was also considered through working with the research supervisor to be aware of perceptions and how/if these might obstruct the study, thus enabling a transparent interpretation of the research (Finley and Gough, 2003; Smith et al. 2009).

Reflexive Statement

To fulfil the double hermeneutics role of the researcher I needed to identify what my own interest was for carrying out this study and how my presuppositions may

influence my position (Etherington, 2004). As a psychotherapist I had worked within an agency that dealt with clients who had been sexually assaulted in childhood. This led to my interest in researching further this area, and when I explored what research had been carried out with other therapists that worked in this field, I found there was virtually none. I went on to work in private practice, but still predominantly worked with sexual assault and recognised the complexities involved with working with this client group. I reached out to other colleagues in peer supervision for support, but found that few seemed to be fully aware of what the CPS guidelines recommended and only had a vague idea of what may be required if working with a client pre-trial in this field. I found when I was searching for participants at the start of my study that I had a very low response from private practitioners and wondered whether this lack of confidence in working within the CPS guidelines with clients' pre-trial may be a reason for this. This led to my interest in exploring other therapists' experience of working in this field and I wanted to examine what this was like for them.

I was aware that my own personal knowledge and experience could distort my interpretation of the participants' phenomenology (Coolican, 2013). In order to create a reflexive practice I kept a journal detailing my thoughts and feelings and worked to separate these from those of the participants (McLeod, 2011). However, Douglas and Moustakas (1985), defined the concept of heuristic inquiry which highlights the researcher using 'self' as a positive giving deeper insight into the research. So, I worked with my supervisor to ascertain whether my personal responses were hindering the study or whether they could arguably prove useful, as my experience as a therapist working pre-trial, may have helped me to understand the participants sense making practices (Etherington, 2004; McLeod, 2011). Another reason why I may have been in a good position to make sense of the meaning-making practices of the participants, was that I was in a similar professional role, was of a similar age,

social class and ethnicity as the participants. Arguably, this also, may have influenced how comfortable they felt in the interview, and meant my analysis was more accordant with their perspective than possibly if I had been from a different culture.

I was also aware I had experience of working in both agency and private practice and was mindful that my own social contexts didn't impede the study and actively worked, through supervision, to bracket my own assumptions (Etherington, 2004; Husserl, 1927).

Sample Size and Sample Method

The idiographic format of IPA, focuses on detailed analysis of individuals in the attempt to examine their specific phenomenon, this necessitates a small sample size, which is selected purposively to ensure that participants are able to offer insight into the particular experience the research project is exploring (Coolican, 2013; Smith et al. 2009; Smith and Osborn, 2004). Reid, Flowers, and Larkin (2005) challenged the view that small sample sizes decrease validity, they stated the multiple perspectives used to study one phenomenon produced a more in depth and multi-layered account of the phenomenon which increased validity (triangulation).

Smith et al. (2009), suggested a sample size between three to six participants for a Masters IPA study and stated that number would provide the necessary cases to acquire rich and meaningful data without overwhelming the researcher, so six participants were interviewed for this project. Smith et al. (2009) also suggested that this size is adequate to obtain meaningful data that would show differences and similarities between participants.

The research question needed to be meaningful to the participants so that they would have an understanding of the topic (Smith et al. 2009). The invitation to take part in the study was, therefore, sent to participants that were homogenous in that they were all qualified practicing counsellors, psychotherapists or psychologists, that had experience of working with clients who had been sexually assaulted and had worked within the CPS guidelines pre-trial.

The following inclusion and exclusion criteria were specified to achieve the comparatively homogenous sample group required:

Table 1: Inclusion and exclusion criteria for participants

Inclusion Criteria	**Exclusion Criteria**
To be qualified practising counsellors, psychotherapists or psychologists to a minimum of diploma level.	Therapists who had experienced their own trauma within the last year.
To have one years' experience of working with survivors of sexual violence.	Therapists who were undergoing therapy due to a traumatic experience or significant levels of distress.
To have experience of having worked with at least one client pre-trial within the CPS guidelines who have reported sexual assault.	Therapists who were not currently working due to their level of distress.
To have regular clinical supervision and agreed to discuss with their supervisor any issues that may have arisen from the interview.	Therapists who had experienced vicarious trauma, burnout or compassion fatigue in the last year.
	Therapists who were employed by the NHS. (Due to the time restrictions as it would be necessary to go through the NHS ethics committee).
	Participants not sufficiently fluent in English, as I only speak English and funds were not available for interpreters.

To recruit potential participants who met the criteria a two-part strategy was implemented as the sample of participants were potentially limited and hard to reach. The first part of the recruitment strategy was to send an email (Appendix 1) to service managers of the sexual abuse organisations in the East Sussex area to request they forward a potential participant invitation letter (Appendix 2) and participant information sheet (Appendix 3) to therapists that worked within their organisation. The second part was to use a snowball sampling method (Noy, 2008) in which an email (Appendix 4) was sent to an existing network of colleagues with a request for them to forward the potential participant invitation letter and participant information sheet to therapists in their network.

The potential participants were then asked to contact the researcher directly to express their interest, in order not to compromise anonymity, and this was followed by a telephone conversation to confirm they met with the criteria and to answer any questions they had. Prior to meeting a consent form was sent to them to sign and return (Appendix 5). Interviews were then arranged with each participant, at a mutually convenient time and venue or online via Zoom.

Of the six therapists recruited, five worked within an agency setting, five were females, one male, their age ranged between 45 – 65 years old and all were of white British ethnicity.

Quality Considerations

Validity and reliability do not carry the same meaning in quantitative research, where the focus is on stability and generalizability, as they do in qualitative research (Cresswell, 2014). Validity in qualitative research is a much discussed topic and

relates to the credibility, authenticity and trustworthiness of the study (Cresswell and Miller, 2000; Lincoln, Lynham, and Guba, 2011). Yin (2003) suggested the way to conduct a qualitative study to ensure reliability, was to handle each stage of the research transparently as if every step was being observed. There are a number of frameworks used to judge the quality of a qualitative research study, however, the core guidelines outlined below were applied throughout this research project (O'Reilly and Kiyimba, 2015):

Transparency - There were a considerable number of extracts from transcripts of the participant interviews, directly quoting their experiences which gave them a voice in the research and also illustrated the interpretations that were being made, ensuring the process of data collection and analysis was clearly demonstrated. Mini audits of the participant extracts and deployment of themes that were presented, were verified through supervision (Smith et al. 2009).

Reflexivity - A reflexive statement had been included to demonstrate the researcher's awareness of how their own personal and social constructs could impact the findings.

Transferability - This was discussed further in the discussion section of the research, however, it is anticipated that findings from this study would be used to help therapists working in this field and may be used in devising new policy and identifying further research that may be required.

Ethicality - An important part of the research that was covered in depth in the confidentiality and ethical issues section.

Integrity - Starting from a critical realist position the methodology, method and data collection techniques considered, needed to be congruent with the epistemology, which is why IPA was chosen as a compatible methodological approach.

Data Collection

Semi-structured individual interviews were conducted as this allowed enough flexibility for the participants to tell their stories in detail, giving them the opportunity to reflect on the information they were delivering and to speak freely and at length, providing the researcher with the 'rich data' that was required (Reid et al. 2005; Smith et al. 2009). Other forms of collecting data were considered, such as, structured interviews or questionnaires, however, structured interviews could be restrictive and not allow the participant the freedom to tell their story and questionnaires have been shown to produce limited information as the participant had not been encouraged to engage in deeper disclosure (Smith et al. 2009).

Three of the participants were interviewed face to face in an agreed, mutually convenient, confidential and secure office space. Due to the difficulty in recruiting participants in the local area, three of the participants were interviewed remotely online using Zoom. Zoom was used as it offered a fully secured service with encryption. The participants that were interviewed online were asked to access a secure space where they could not be overheard and were unlikely to be interrupted to carry out the interview. Prior to the interview it was agreed that if connection was lost, the researcher would contact the participant via telephone to ensure the well-being of the participant and to reinstate or reschedule connection. The participant information sheet and a list of support organisations, in case required, were emailed

to the participant and discussed before the interview commenced. The interviews were recorded using an electronic recording device.

A draft scheduled interview questionnaire was prepared as a guide that could be drawn upon to ensure gaps found in the literature search were addressed and to allow the researcher to be more relaxed and attentive in case any difficulties arose (Smith et al. 2009). A pilot interview was carried out with a colleague to practice the questions and get feedback from the participant (Bor and Watts, 2011). This highlighted areas that appeared stuck and where further questions were needed to encourage more detailed information from the participant. It further enabled refining of the questions to ensure the interview questions related to the research question and the participants experience rather than any presuppositions of the researcher (Reid et al. 2005).

Following the pilot interview a revised scheduled interview questionnaire (Appendix 6) of 8 open ended questions was produced to reduce the likelihood of participants being led into answering in a particular way and encouraged detailed, expansive accounts of their experiences (Reid et al. 2005; Smith et al. 2009). Prompts were also constructed to encourage further exploration or deeper disclosure from the participants if required (Smith et al. 2009).

Data Analysis

The first step of analysing the data involved transcribing the audio recordings. Each participant's transcript was thoroughly analysed before moving on to the next interview. The transcript was read and re-read, initially listening to the audio recording at the same time, noticing the participants pitch, emphasis on words, pauses, etc., and making notes of any observations to assist in the complete analysis

of the data (Smith et al. 2009). The repeated reading of the transcripts enabled the researcher to enter the experiential world of the participant, and start to understand something of their concerns and claims (Larkin, Watts and Clifton, 2006; McLeod, 2011).

A table was produced for each participant containing three columns, the original transcript was in the middle and on the right hand side was a column for exploratory comments (example table Appendix 7). The exploratory comments column allowed the researcher to make notes of anything that seemed significant or interesting, such as; descriptive comments - what was said, linguistic comments – exploration of the language used, and conceptual comments – focusing on a more interpretative level (McLeod, 2011; Smith et al. 2009). The exploratory comments were then further reduced by means of identifying the manifestation of patterns, connections, frequency, etc., to develop emergent themes, which were added in the remaining column (Smith et al. 2009). Each emergent theme for all participants were then written out on a card, all the cards were laid out to enable exploration of those themes that were similar and could be amalgamated together or that were polar opposites and this process was used to establish sub-ordinate and super-ordinate themes (Smith et al. 2009). The sub-ordinate and super-ordinate themes were examined in supervision to ensure the credibility of the interpretations (Smith et al. 2009). Five super-ordinate themes and twenty-one sub-ordinate themes were identified which are shown in the Findings section of the research.

Confidentiality and Ethical Issues

The research project was approved by the Research Ethics Committee at the University of Chester and was conducted in accordance with the British Association

for Counselling and Psychotherapy Framework for Good Practice (2018) and Chester University's Research Governance Handbook. Participants were given a pseudonym and any identifiable features, such as, places of work or names of other people, were either removed or changed to ensure confidentiality. Deductive exposure was minimised by using short quotes within the research (Postmes, Spears, Lee, and Novak, 2005).

Participants were provided with a Participant Information Sheet prior to attending the meeting and this was read again at the beginning of the interview to ensure they were fully informed of all aspects of the research and potential risks of participation. Where possible risks were minimised by means of the inclusion and exclusion criteria for participation. An Informed Consent Form had been signed prior to the interview taking place. Participants were informed that they were able to completely withdraw from the research study up until the point where the transcripts would be written up for the research and it would not be possible to replace their participation.

The interview audio recordings were stored on a password protected file on the computer and the original recordings were deleted. A debriefing took place at the end of the interview to check the well-being of the participant and they were given an information sheet (Appendix 8) with details of support organisations that were available if required.

Chapter 3

Findings

Six participants were interviewed and pseudonyms were used to protect anonymity. Five participants worked within an agency setting that specifically worked with victims of sexual assault and one was in private practice.

Upon analysis of the data, five super-ordinate and twenty-one sub-ordinate themes emerged which are shown in diagram one.

Diagram 1: Super-ordinate and sub-ordinate themes

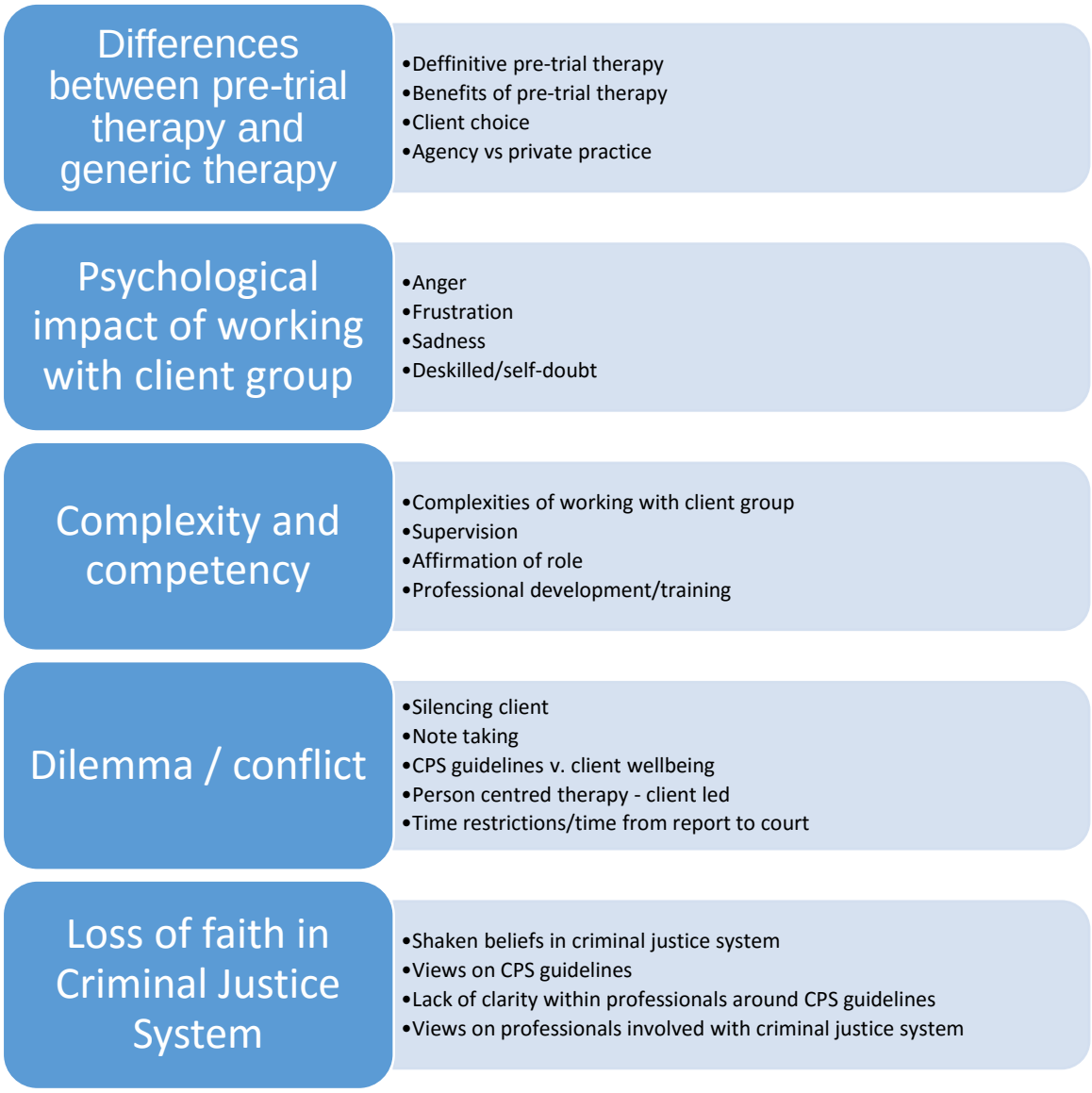

Table 1 below shows each super-ordinate theme with details of the participants that spoke about this theme in their interview.

Table 1: Identifying recurrent themes

Super-ordinate Themes	Cathy	Beth	Susie	Rachel	Janet	James	Present in over half of sample?
Differences between PTT and generic therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Psychological impact of working with client group	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Complexity and Competency	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dilemma / Conflict	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Loss of faith in Criminal Justice System	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Super-ordinate Theme 1: Differences between Pre-Trial Therapy and Generic Therapy

Therapy provided before a client appears as a witness/defendant in a court case is referred to as pre-trial therapy (PTT). There are clear guidelines in pre-trial therapy about what can and cannot be discussed (CPS, 2001).

Therapists working pre-trial may also be required by the court to provide a copy of their clinical notes or in some circumstances may be called to court to give evidence. Generic therapy, however, relates to therapy with a client that is not awaiting trial and there are no specific restrictions about what can be discussed apart from the usual confidentiality and safeguarding regulations of the governing body the therapist

belongs to. This super-ordinate theme relates to the way participants interpreted these differences in relation to their work with clients. Table 2 shows the four sub-ordinate themes within this super-ordinate theme.

Table 2: Sub-ordinate themes within the super-ordinate theme of differences between PTT and generic therapy

Sub-ordinate Themes	**Cathy**	**Beth**	**Susie**	**Rachel**	**Janet**	**James**	**Present in over half of sample?**
Definitive Pre-trial Therapy	Yes	Yes	No	Yes	No	Yes	Yes
Benefits of Pre-trial Therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Client Choice	No	No	Yes	No	No	Yes	No
Agency Vs Private Practice	Yes	Yes	No	Yes	No	No	Yes

1.1: Definitive Pre-trial Therapy

The five participants that worked for agencies stated there was a policy in place that informed them of the pre-trial procedure and they did inform clients that they would not be discussing the evidence of their case. Even so, not all thought this changed the way they worked, and Janet felt she worked the same *"I'd say the way that I work is the same whether it's pre-trial or not pre-trial, I work with whatever it is the client brings into the room"* (p6. 221 – 223).

Three participants talked about having a very definite pre-trial procedure that they put in place. From the first meeting, they explained to the client they would not be speaking in detail about the incident itself in the sessions, as this may contaminate the evidence and potentially jeopardise the court case. Rachel went as far as

providing a written contract that she asked the client to sign to show they understood and gave informed consent.

> Rachel: *"If a client isn't sure whether they want to report I don't start generic counselling, I start with pre—trial therapy because otherwise we've already started talking about the detail of what happened. So I have a written contract, I think that's really important, so the client is aware of why we're working in this way"* (p9. 397-400).

In contrast, James worked in private practice and did not have a pre-trial policy in place and therefore, had already started working on the abuse with the client using EMDR, before the client reported the incident to the police. Once the client did report they agreed to change the focus of their work and protect the evidence by stopping EMDR.

> James: *"That we'd simply stop doing the EMDR on the abuse at that point once it became pre-trial"* (p4. 167 – 171).

1.2: Benefits of Pre-trial Therapy

All the therapists believed that pre-trial therapy was beneficial, from 'strengthening' their clients to managing their 'feelings' attached to the event, and in one instance, providing the basis for the case. Janet thought it was important to concentrate on the feelings associated with the incident *"the important thing with counselling, it's talking about the feelings"* (p1. 32) and building the client's confidence helping them take back control *"building up confidence and actually and talking about control"* (p10. 417 – 418).

Susie acknowledged that the focus was on the impact of the event *"it's much more of a focus on the impact rather than what actually happened to the person"* (p8. 344 – 345).

Rachel saw the importance of preparing the client for their court appearance, *"I think the therapist can do the court preparation. In terms of what happens in the room, um, a lot of it is about, you know, confidence building, giving them choices"* (p10. 445 – 447).

Beth identified the benefit of introducing stabilisation techniques to the client, as well as building their self-confidence and improving their self-care.

> Beth: *"So it's about for me, resourcing clients so that they're in a stronger place than they are when they came in, so giving them some regulation"* (p4. 139 – 140).

Conversely, James had a different experience of pre-trial therapy as he did work on the abuse with his client before the client reported. Having had this experience his perception of how the therapy benefitted his client differed in some aspects from the other participants, as he believed that the court case would not even have gone ahead without the therapy.

> James: *"my client also was clear from his conversations with, er, the Crown Prosecution Service, that without my notes, without my … without me, without the therapy there wouldn't have been a case"* (p7. 323 – 326).

1.3: Client Choice

Two participants discussed the prospect of giving the client choice regarding talking about the incident pre-trial. James referred to the ambivalence of the CPS guidelines

and how this ultimately would need to be discussed with the client and if the client gave informed consent, he would continue working on the evidence.

> James: *"there's an ambivalence I felt in the guidelines"* (p4. 163 – 164) *"but the CPS guidelines do also have the rider that, er, that the actually, ultimately with the interest of the client. The wellbeing of the client comes first. Um, it's something one would need to discuss with the client"* (p18. 843 – 845).

Others seemed more concerned about the consequences of giving the client the choice and struggled with leaving the decision to the client.

> Cathy: *"So, if I had somebody who said, you know, I desperately, desperately need to tell you what he did to me then I would be in a conflict because I would have to say to that person, look, I'm sorry, um, I know you want to talk about that but … but I .. I know that that might affect your ability to have a successful trial and you may not be in a position to make a good decision about that right now"* (p16. 654 – 659).

When working generically with a client, there seemed to be a consensus that this problem didn't arise. This was demonstrated by Susie who stated that *"you can go wherever you want to without having to worry about it"* (p10. 426 – 427) and Beth, who felt that when *"there won't be a court case, that's not going to happen, then there is a real, I suppose relaxation"* (p11. 449 – 450).

1.4: Agency v. Private Practice

Three participants were very positive about working within an agency setting, and Cathy made the point that she was grateful to be working for an agency as she had the CPS guidelines 'drummed' into her.

> Cathy: *"I'm just so grateful that my experience of pre-trial therapy is being in an organisation which specialises in it and therefore where we have drummed into us the whole thing about the CPS guidelines"* (p20. 775 – 778).

Similarly, Beth talked about the benefits of belonging to an agency as a way of being part of a support network, *"we have what's called an area lead, that if I see a client I have concerns for I can raise that straight away"* (p7. 305 – 306).

James, however, did not have the same kind of support in place when his client decided to report a year into their work together. He sourced information regarding the CPS guidelines where possible and went to his governing body at that time for reassurance and support.

> James: *"I read up on it and I rang … um, I rang the BACP which I was still a member of in those days and the UKCP, I Googled it and, you know, checked as much as I could"* (p4. 157 – 160).

The "I" suggesting the solitude that may be felt in private practice when faced with a concern in contrary to the readily available support network described by Beth in the agency.

Super-ordinate Theme 2: Psychological Impact of Working with Client Group

All participants talked about the emotional impact they experienced in varying degrees within their work. Feelings of anger and frustration were felt by all six of the therapists relating to different aspects of their work. At times they described mirroring the emotions felt by their clients, or an intensity of emotion on behalf of their client, or in some cases it was related to the justice system and professionals within the

system. Table 3 shows the four sub-ordinate themes within this super-ordinate theme.

Table 3: Sub-ordinate themes within the super-ordinate theme of psychological impact of working with client group

Sub-ordinate Themes	Cathy	Beth	Susie	Rachel	Janet	James	Present in over half of sample?
Anger	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Frustration	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sadness	Yes	Yes	Yes	Yes	Yes	No	Yes
Deskilled/Self Doubt	Yes	Yes	Yes	No	No	No	Half

2.1: Anger

All six of the participants described feeling angry when they thought their clients had been treated unfairly. For example, Janet spoke of her client being humiliated in court and how difficult she found that *"for her it was a really, really humiliating experience and, um, I found that really difficult"* (p6. 241 -242). She was angry as her client changed after this experience *"I was angry, um, she … she was like a different person"* (p6. 255 – 256). The court experience had changed her client and had a negative impact on her *"I …. I did really struggle"* (p6. 262) *"I was left with feelings of anger and frustration and great sadness for her"* (p7. 278 – 279).

Cathy referred to the work the client had done and how he was deflated when the CPS decided not to proceed with his case and how she in turn mirrored his emotions.

> Cathy: *"so he was working really hard for himself and other people and then … just talk about, you know, burst balloons!"* (p4. 142 – 143). *"I felt … er ….. angry, disappointed, sad, er, deflated"* (p4. 147).

The client's experience in these cases had a large impact on the therapists indicating the depth of the relationship that is built between therapist and client and how the client's reactions and emotions affect the therapists.

2.2: Frustration

Frustration was expressed by all six participants. Susie found the timeframes of the Criminal Justice System frustrating, as there was nothing she could do to speed up the process.

> Susie: *"I think frustration is the biggest thing, you just … because this person has plucked up the courage to actually report, they're going to go through the Criminal Justice System, which we know is not an easy thing to do, and for it to drag on for such a long time is horrible for them. So for me it's frustration more than anything else"* (p3. 89 – 92).

Beth also felt the frustration of her client not being allowed to talk about what happened to her *"so it is frustrating, it is frustrating"* (p9. 387 – 388). *"It is frustrating, I get that. It's the only thing you want to talk about and it's the only thing you're not allowed to"* (p9. 390 – 391). Additionally, Rachel believed that clients are given mixed messages from the police and other professionals as to whether they are allowed to have counselling and this frustrated her, so much so that she now offers her own training on pre-trial therapy.

> Rachel: *"There just needs to be a huge amount of promotion, training ..."* (p13. 559 – 562). *"I feel really angry and frustrated! Yep, so I've done training in various different places"* (p13. 565 – 566).

2.3: Sadness

Sadness was expressed by five participants, relating to the sadness and injustice of the court verdict, for the experience the client had gone through and for the complexities of the life the clients may lead. For example, Rachel spoke of a client that the police had referred as it was a complex case and the client was in danger. The client was murdered whilst working with Rachel and this was a horrifying experience for her and left her shocked and very sad.

> Rachel: *"she was quite brutally murdered"* (p2. 67) *"part of me was sort of horrified that this could have happened and in shock just … and I'd walk round this house sometimes and see, you know, young women that look like her and sort of, you know, have sort of a flashback to working with her"* (p3. 106 – 109). *"I came into her life at a very difficult time. Um, yeah, and very sad that it was … it was cut short, we didn't have that opportunity for her to make a better life"* (p3. 112 – 113).

A horrific experience for Rachel that had a psychological impact on her leading her to experience flashbacks and leaving her full of sadness for the loss of an opportunity to help the client. Susie described the upset she felt when a client blames themselves for what happened to them *"it wasn't rape, it must be my fault – that's one of the things that upsets me the most"* (p5. 190 – 191).

Beth expressed her distress when the perpetrator of a client she had been working with was acquitted *"Oh I wept. I wept. Not with her but when she left I wept. And when I went home I wept and I rang my supervisor and wept and I rang my clinical director and I wept. And I had a huge long shower. That really did impact me"* (p12. 536 – 538).

Needing to release her emotions and recruit the help of her supervisor and clinical director to express her sadness over the verdict. The ‘huge long shower’ suggesting she felt there was something unclean about it.

2.4: Deskilled/Self-doubt

Three of the six therapists questioned their own skills or decisions they had made. When a client regressed after a not guilty court verdict, Cathy questioned her skills, as the work they had done together was “demolished”.

> Cathy: *“I felt disappointed in myself that I hadn’t done a good enough job with her. And um, very sad for her because what had happened was that we’d done a lot of work on self-esteem and all this kind of thing which was just demolished by, um, the experience of the trial”* (p2. 45 – 48).

The use of the phrase not ‘a good enough job’ implies in some way that she felt responsible. Similarly, Beth questioned her decision not to attend court as a witness in support of her client, after the not guilty verdict *“I started to think oh maybe I should have gone to court, maybe it might have made a difference”* (p13. 550 – 551).

She blamed herself in some way and believed if she had attended ‘it might have made a difference’.

Super-ordinate Theme 3: Complexity and Competency

The therapists discussed the complexities of cases they worked with, describing other factors that needed to be addressed such as; suicidal ideation, chaotic lifestyles, PTSD symptoms and there were varying degrees of competency in working in these areas. Some had undertaken additional training, which together with validation of their work through supervision or demonstrated through the positive

changes in their clients also increased their competence. Table 4 shows the four sub-ordinate themes within the super-ordinate theme.

Table 4: Sub-ordinate themes within the super-ordinate theme of complexity and competency

Sub-ordinate Themes	Cathy	Beth	Susie	Rachel	Janet	James	Present in over half of sample?
Complexities of working with client group	Yes	Yes	No	Yes	No	Yes	Yes
Supervision	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Affirmation of Role	Yes	Yes	No	Yes	Yes	Yes	Yes
Professional development/Training	Yes	Yes	Yes	Yes	Yes	Yes	Yes

3.1: Complexities of Working with Client Group

Four participants talked about additional issues within this client group that added further complexities. For example, Rachel discussed a client who displayed symptoms of PTSD within sessions *"other things have come out about a previous rape, um, there were toxic parents involved in her upbringing"* (p5. 189 – 191). *"She completely zones out, dissociates, major, um, flashback, panic attack, um, and the rest of the session is just gone"* (p5. 199 – 200).

Rachel recognised her limits of competency with this client and looked to refer to another therapist, *"I'm definitely not an expert in working with PTSD. This client I'm working with currently who, um, while I was away for six weeks, um, went off for some EMDR. She's certainly suffering from complex PTSD"* (p8. 340 – 343).

Beth believed that 20% of the clients she worked with had a diagnosis of PTSD. She described these clients as riskier to work with as they had a number of other issues, *"PTSD clients that I work with who are having flashbacks, who perhaps are actively self-harming a way of coping with their feelings, … become much more riskier clients*

to be working with" (p7. 293 – 296). Consequently, Beth found the clients with PTSD harder to work with because she worried about her competency in working with them, *"I'm worried about, you know, what I'm doing and about getting it right"* (p7. 300).

3.2: Supervision

All participants talked about the importance of supervision. Some in relation to offloading their emotions so it did not impact their work, others for reassurance from their supervisor about their work. James felt angry on his client's behalf, but needed to address this in supervision, as he did not want it to affect his client work.

> James: *"I was angry on his behalf and I took it to supervision, you know, I was very angry. But I didn't let …. I didn't want to let that leak into …. Into the work"* (p6. 278 – 279).

When Janet felt anger, frustration and sadness for her client after she went through the court experience *"feelings of anger and frustration and great sadness for her, um, after all she'd gone through"* (p7. 278 – 279), she dealt with her feelings in supervision and also emailing a complaint to her head of service *"taking it to supervision and writing, um, an email to our head of service … and I think that for me that … those two things was a release of the … the feelings that I had"* (p7. 282 – 284).

Cathy doubted herself when her client regressed when the CPS didn't proceed with his case and her supervisor reminded her of the good work that had been done. Cathy: *"Come on now, OK, you may be able to not see at this minute but, um, you know, there was some good work going on. That was what my supervisor was saying to me"* (p6. 234 – 237). Additionally, Beth spoke about her supervisor's experience and advice, reassuring her she is doing the right thing with her clients *"her*

experience and advice that she gives us confirms what we're doing here and … and … and the framework that we're using" (p7. 267 – 269).

3.3: Affirmation of Role

Five participants expressed how rewarding they found their job when they could see positive changes in their clients and how this affirmed their role within this process. Beth spoke about how counselling can be life changing for somebody, and by seeing her client 'bloom' it confirmed her role.

> Beth: *"you just see the beginning, to actually see her bloom it was beautiful. Um, it was really affirming, golly, this counselling can be life changing for somebody"* (p5. 187 – 189).

Janet mirrored her client's positive feelings from therapy, when the client was empowered and Janet felt herself energised and empowered by the work.

> Janet: *"I think, yes, I think that's the word, I felt energised and, um, she was … she felt really … she found the whole work really empowering"* (p7. 299 – 301). *"I was sharing her experience and so I … I found it really empowering and, um, energising and, um, yes, I was on a high"* (p7. 303 – 304).

Alternatively, James was believed by the court when he appeared as a witness, and this validated his professional role and his competence.

> James: *"my testimony, er, being believed and also, me as a professional being validated. So, I … I felt very, I felt very validated actually by the process of knowing what I was doing, feeling very competent"* (p13. 556 – 558).

3.4: Professional Development/Training

All the therapists interviewed had continued with their professional development and five had undertaken further training. Four worked for an agency, and had undertaken a day's workshop on pre-trial therapy upon joining.

> Cathy: *"one of the things that, um, we're all encouraged to do when we join 'agency' and which I did, was to go to Brighton … and to do their day on pre-trial therapy"* (p3. 84 – 86).

Additionally, Rachel believed there should be more training given to therapists on pre-trial therapy during basic training. She found this wasn't provided when she did her degree, even though there was a module on sexual abuse, which she thought was very wrong.

> Rachel: *"I think there should be more promotion of it, more, er, in basic training. So, I …. I did a top-up at the end of my degree … and one of the modules, was sexual abuse and they didn't mention pre-trial therapy"* (p13. 548 – 551). *"So, I think there's something very wrong"* (p13. 552).

Beth undertook further training to work with PTSD *"I've just recently done an online course with NScience and its PTSD, er, working in a CBT approach"* (p7. 286 – 287).

Alternatively, James was enthusiastic about working with clients who had experienced trauma, and he felt his EMDR training gave him a tool to use that he was confident could make a difference *"I'm so enthusiastic about trauma, but, you know, you can tell me the worst possible story and I think yes, yes, let's get in and do something about it. And because with the EMDR especially, attachment focussed EMDR, I've got a tool that really makes a difference"* (p5. 225 – 230).

Super-ordinate Theme 4: Dilemma / Conflict

All the therapists spoke about situations that had or would cause them a dilemma or conflict when working pre-trial with their clients with the CPS guidelines. The five sub-ordinate themes shown in Table 5 represent the areas that emerged that caused either a dilemma or conflict for participants.

Table 5: Sub-ordinate themes within the super-ordinate theme of dilemma / conflict

Sub-ordinate Themes	Cathy	Beth	Susie	Rachel	Janet	James	Present in over half of sample?
Silencing Client	Yes	Yes	Yes	No	No	Yes	Yes
Note Taking	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CPS Guidelines Vs Client Wellbeing	Yes	No	Yes	Yes	No	Yes	Yes
Person Centred Therapy – Client Led	Yes	Yes	No	Yes	Yes	No	Yes
Time Restrictions/Time from Report to Court	Yes	Yes	Yes	No	Yes	Yes	Yes

4.1: Silencing Client

Four participants felt a dilemma regarding stopping the client if they wanted to talk about what had happened to them. Cathy experienced an ethical dilemma to put the trial and CPS guidance before the autonomy and beneficence of her client as outlined in the BACP ethical framework, if the client felt it was important to talk about it.

> Cathy: *"maybe it's really important that she says it and that the trial is not the thing that matters. … it's a big ethical dilemma … because autonomy of clients is such an important thing and beneficence and all those other BACP*

> *ethical framework things, um, you know, and … (sigh) .. at the end of the day, how do I balance all those different needs?"* (p17. 682 – 686).

Susie thought it was almost repeating the abuse to tell someone they're not allowed to say something they are desperate to say - she felt it was very controlling and she found that uncomfortable.

> Susie: *"to not allow someone to … to actually say something that they, you know, they they're desperate to say, to me that's almost repeating the abuse, because it's being very controlling and I just find that doesn't sit well with me at all"* (p11. 456 – 459).

Additionally, James thought it was potentially deeply traumatising to a victim of sexual abuse not to work on the abuse.

> James: *"I think that it is potentially deeply traumatising to a … to a victim of sexual abuse. I think, er, a balance clearly needs to be found"* (p18. 834 – 837).

4.2: Note Taking

All of the therapists talked about the notes they took and all were aware that these could be subpoenaed by the court. For example, Susie spoke about how counsellors in her team were trained how to write their notes with the courts in mind, so that if a client changed their mind and decided to report, the court-case wouldn't be undermined *"but we will train all of our counsellors to write their notes with the courts in mind, so that should the person change their mind, you haven't written anything down that's going to undermine the case"* (p3. 103 – 105).

However, there were different opinions regarding how and what they wrote in their notes.

Susie was not comfortable stopping the client talking about what happened to them, so she chose to allow them to say a bit about what happened, but would not record it in the notes.

> Susie: *"they're not allowed to talk about it and now I just think that is ridiculous. Um, and I … I feel much more comfortable to let them say a bit and often they don't want to say too much actually, um, and I just don't put it in the notes basically"* (p3. 114 – 116).

Rachel liked to be completely transparent with the notes she wrote and would give them to the client to read in the following session.

> Rachel: *"and the way I work pre-trial is that I show the clients the notes that I've made in the following session and I feel very strongly about that because it give them … it's completely open"* (p2. 72 – 74).

Alternatively, James wrote two sets of notes for his client, one set relating to the EMDR process and another that he used to summarise what happened in the session afterwards.

> James: *"Two sets of notes, there's my session notes which are very comprehensive actually on what happens in EMDR and then my computer processed notes summarising the … session afterwards, just for my own purpose and continuity"* (p9. 385 – 388).

James was conscious that the case rested on his notes and with his client's consent, worked transparently with the CPS and gave them all the notes he made.

> James: *"I gave them the lot."* (p9. 390). *"I was aware very … very … very … definitely that the case rests on these notes, so with my completely talking it*

> *through with my client, we agreed that I would work completely transparently and openly with the Crown Prosecution Service"* (p9. 392 – 395).

4.3: CPS Guidelines v. Client Wellbeing

Four therapists expressed a dilemma between abiding by the CPS guidelines and consideration of their client's wellbeing. For example, James expressed concern about the time taken before the case goes to trial which he felt was unethical *"it was two years before it came to trial, do you leave somebody whose life is in a serious mess?"* (p18. 838 – 840). *"do you withhold treatment for two years? I mean no, I think that's unethical"* (p18. 842 – 843).

He thought the wellbeing of the client came first and if the client gave informed consent, he would carry on working on the material presented. He referred to seeing a client as 'drowning' which implies he believed they may be struggling to survive, and said he wouldn't want to leave them like that.

> James: *"what's more important, the purity of the evidence and the needs of the case or the wellbeing of the client … Sorry! I'm not going to leave a client, you know, if somebody's drowning you don't say I'll be back in two years' time"* (p19. 846 – 850).

Rachel believed the legal profession didn't want therapists interfering and felt they were putting the conviction at trial before the wellbeing of the client *"legal profession actually don't want us interfering, so they are putting, um, I guess the … the trial and getting a conviction before the wellbeing of the client, our clients"* (p13. 554 – 556).

Susie would discourage clients from going into detail, but if they expressed a need to talk about what happened to them, she was not comfortable stopping them.

> Susie: *"certainly I wouldn't encourage anybody who is going through pre-trial to discuss it. And certainly if they really wanted to go into a lot of detail I would actively discourage that. But I think if someone really needs to say something, to actually tell them they can't, um, is … I'm … I'm not comfortable with that"* (p9. 363 – 366).

4.4: Person Centred Therapy – Client Led

Four therapists were Person Centred, which they described as client led. Hence, Cathy anticipated the conflict she would have if a client wanted to talk about what had happened, as it would challenge her person-centred way of working, which was to let the client choose what they spoke about.

> Cathy: *"if it happened that I had a … a client with whom I was working pre-trial who really wanted to talk about what had happened then I would have a bit of a conflict because of the way that I chose to work which is in a very person centred way and which is giving, as a client, the choice about what we talk about"* (p18. 689 – 693).

Her conflict would be that if she allowed this, it may affect the outcome of the trial, but by stopping the client talk it implied she was not client led.

> Cathy: *"I would be in a conflict because I would have to say to that person, look, I'm sorry, um, I know you want to talk about that but … I … I know that that might affect your ability to have a successful trial"* (p18. 693 – 697).

Similarly, Janet explained that she was client led, as much as she could be, which suggests there are times when she was not able to be, *"I'm very sort of client … well, I am as much as I can be, client led"* (p9. 364 – 365).

The implications by Cathy and Janet are that they work in a very client led way, however, if the client chooses to talk about what happened to them, that opposes the CPS guidance and may lead to a dilemma in their decision making.

4.5: Time Restrictions / Time from Report to Court

Five therapists described dilemmas relating to time, either regarding time restrictions placed on them from the agency they worked at, or difficulties attached to the time from the client reporting the offence to a court date.

Beth experienced a sense of powerlessness at the lack of control she has over the time the investigation takes and her anxiety that it will still be going on when they have run out of sessions.

> Beth: *"Well, yeah, because you feel quite impotent because I don't have any authority to speed any of it up. My anxiety then is we're running out of sessions and it's still going on"* (p3. 104 – 106).

Susie felt frustration that she was unable to offer the clients the time they needed in therapy.

> Susie: *"I think it's a sense of frustration as much as anything, looking at this person and thinking, OK, I think you really need long-term therapy, we can't give you that"* (p8. 316 – 318).

Janet explained the difficulties she experienced trying to pace the sessions the agency offered over the length of time the criminal investigation took.

Janet: *"We're able to offer eighteen sessions, um, with another four if it goes to trial"* (p2. 50 – 51) …

"it takes a very, very long time for it to, you know, to go … for the police to gather all the evidence and then it goes to the CPS and … and so trying to pace things is very … it's difficult" (p2. 53 – 55).

Super-ordinate Theme 5: Loss of Faith in the Criminal Justice System

Working with this client group had led some therapists to lose faith in the Criminal Justice System. They build close relationships with their clients and found it difficult when a not guilty verdict was given or the case didn't go to trial. The four sub-ordinate themes in this category are shown in table 6.

Table 6: Sub-ordinate themes within the super-ordinate theme of loss of faith in the Criminal Justice System

Sub-ordinate Themes	Cathy	Beth	Susie	Rachel	Janet	James	Present in over half of sample?
Shaken Belief in Criminal Justice System	Yes	Yes	Yes	No	Yes	Yes	Yes
View of CPS Guidelines	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lack of Clarity within Professionals around CPS Guidance	No	Yes	Yes	Yes	No	Yes	Yes
Views on Professionals Involved with Criminal Justice System	No	Yes	Yes	Yes	Yes	Yes	Yes

5.1: Shaken Belief in the Criminal Justice System

Five therapists expressed negative opinions of the CJS as a result of their experience with clients. Janet spoke of a client that had gone to court only to be told the trial had been cancelled, and struggled to understand how her client went through so much for the court process to then let her down.

> Janet: *"and then for it just not to happen at all, what a let-down"* (p6. 260) …
>
> *"I did really struggle with the court, um, you know, myself with, um, actually this … this court process … it costs the client so much to … to go through this process … and then this happened to her"* (p6. 262 – 265).

Cathy found that her experience of working with clients at her agency had shaken her whole belief in the British justice system, *"I guess I have had my trust in the British justice system shaken by this whole experience of working at 'agency'"* (p13. 511).

The difficulty of being able to predict a verdict wobbled Cathy's faith in the justice system that she believed in, but her experience demonstrated the system didn't always provide the verdict she had expected.

> Cathy: *"everybody can do everything they possibly can and then for some reason or other the guy gets off or the woman gets off. So, there isn't any certainty. And, um, you know, I find that a bit wobbling. If that's the right word. Because I do believe in British justice … and I do believe in the jury system but my … my experience is that they don't always come up with the goods"* (p13. 513 – 518).

Additionally, Susie didn't believe in the verdict of the courts, *"I think that, you know, just because someone gets acquitted absolutely doesn't mean that they didn't do it"* (p4. 143 – 144). She had no faith in the justice system when it came to this type of

crime (sexual assault), *"I don't think our justice system when it comes to this kind of thing delivers any justice at all"* (p11. 461 – 462).

5.2: View of the CPS Guidelines

All participants expressed a view of the CPS guidelines, but they differed in their opinions. Four therapists thought there was an ambiguity attached to the guidelines or felt they had to abide by the guidelines to ensure they weren't responsible if the was thrown out of court. Whereas, two of the therapists believed they gave them a framework to work within.

As James had used EMDR with his client before the offence was reported, he expected, in accordance with the CPS guidelines, that his evidence may be dismissed or undermined in court, however, it was not challenged.

> James: *"I was asked about the EMDR in court and interestingly I had been expecting them to … to dismiss, to try to undermine EMDR as a technique but they didn't. They just asked me to explain it and I did"* (p8. 329 – 331).

Beth would rather not abide by the guidelines when her clients wanted to talk about what happened to them, but she believed that her client's case could be thrown out if she contaminated the evidence and feared being responsible.

> Beth: *"I don't want to be the reason they lose a court case if some of their materials gets contaminated through any conversation we're having and it could end up that their case is thrown out or lost and that was because of a conversation we had"* (p6. 242 – 246).

Alternatively, Rachel believed the CPS guidelines gave her a framework to use when practicing her model of therapy, *"I feel what the pre-trial therapy guidance gives me is a framework in which to operate as a person centred therapist"* (p11. 481 – 483).

5.3: Lack of Clarity within Professionals around CPS Guidelines

Four therapists experienced a lack of understanding of the guidelines from other professionals. Janet was working with a client who also had a victim care worker. The care worker gave the client wrong information about receiving counselling.

> Janet: *"the victim care worker said, when she revealed that she had counselling, she really shouldn't have done and that was a disaster. So my client comes back into the … the next session absolutely fuming"* (p1. 30 – 32).

Janet felt that the lack of clarity between professionals means that added distress is caused to clients and in some cases people are not being offered the help they may need.

> Janet: *"they'd be causing people some distress or meaning that people wouldn't get the help they needed even though they were eligible and it might have been available in their area. And that is why I get very cross about … people who were involved in the process that are giving out the wrong information"* (p1. 35 – 39).

Additionally, Susie had a mother and daughter come to the agency and was told by the mother that the police had informed them they were not allowed to have therapy.

> Susie: *"the police came they did actually tell her that neither she or her daughter could have therapy. They told her that she and her daughter could not have therapy because it was going to go to court, that it wasn't allowed and that's just rubbish"* (p9. 383 – 386).

Susie wanted the Criminal Justice System and the police to have more knowledge about pre-trial therapy, *"So you want the Criminal Justice System to know. You want*

the police who are part of that to know that actually they can have therapy" (p10. 402 – 403).

5.4: Views on Professionals Involved with the Criminal Justice System

Five of the therapists had views on the people involved with the justice system, some of which linked with the lack of clarity they found between professionals. Janet believed that those working in the area needed to be more aware of the procedures around pre-trial and the guidance, *"people need to know the rules, regulations, procedures, the … the guidance, if they're going to be working in this area"* (p13. 574 – 575).

Susie thought that the way the justice system worked in sexual assault cases needed to be changed as she felt it was unkind to victims.

> Susie: *"so I just think the whole way that our justice system works is unkind to victims"* (p11. 477 – 478) …
>
> *"So, yeah, the justice system, I'd like to see it completely changed for these kind of cases"* (p11. 484 – 485).

Furthermore, Susie had some strong views on the trial verdict being reliant on the jury decision. She felt the jury were not educated in psychological trauma and so would not understand the symptoms or reactions of people who have experienced a traumatic incident. She also felt that the jurors would have their own 'baggage', therefore suggesting that she believed they would have made prior judgements.

> Susie: *"I just think that juries … they don't get it, they don't understand the impact of trauma, they don't understand things like tonic immobility and they don't understand that women don't scream and cry and, you know, all that sort*

> *of thing. And there's a bit of me that wants to start a campaign for let's educate juries about psychological trauma!"* (p4. 152 – 157) …
>
> *"and all this thing about being judged by jury for your peers, year right! Who come with all sorts of baggage, particularly on this kind of topic"* (p11. 491 – 492).

On the other hand, James believed that the jury based their decision on feelings and that they basically came to a decision based on the way they felt about the evidence given.

> James: *"Jury decides actually on a feeling. Jury's when they sit down, twelve good men and true, you know, most trials when the jury withdraws to, er, to … to come to their verdict, it is a feeling, you know, can we trust the witnesses, can we trust the defendant and they come to a felt judgement on the basis of the evidence"* (p8-9. 370 – 373).

There were some significant super-ordinate themes that emerged from the participant interviews with some strong views expressed as a result of the experience gained from the therapists. The following chapter will provide an opportunity to discuss these findings in more detail, examine them in relation to existing research and explore the considerations for future research.

Chapter 4

Discussion

The aim of this research project was to gain an understanding of the lived experience of therapists who have worked pre-trial with adult clients who reported sexual assault in accordance with the Crown Prosecution Service (CPS) guidelines. An Interpretative Phenomenological Analysis of the interview data identified a number of super and sub-ordinate themes which were represented fully in Tables 2-6. The five super-ordinate themes were, i) the differences between pre-trial therapy and generic therapy, ii) the psychological impact of working with this client group, iii) the complexity of the work, and competency of the therapists, iv) the dilemmas and conflicts inherent in the work, and v) an expression of a loss of faith in the Criminal Justice System.

The complexities of working with pre-trial clients challenged some of the therapists' feelings of competency. Working within the limits of competency for a therapist is a professional issue and an ethical requirement in the UK under the British Association for Counselling and Psychotherapy (BACP, 2018) and The British Psychological Society (BPS, 2018) as also with The British Association for Behavioural and Cognitive Psychotherapies (BABCP) and Health and Care Professions Council (HCPC). The first commitment a therapist makes to a client is to do no harm, and being aware of their own limits of competency is an essential requirement to ensuring this. If a therapist does not abide by the Professional Conduct Procedure of their professional body, they risk a complaint being made against them and if they are found to bring the profession into dispute their membership may be withdrawn (BACP, 2018).

Therapists are often drawn to the profession as ‘helpers’, which may lead them to work with a client they feel obligated to help, rather than take time to reflect on whether the needs of the client are within their levels of competency (Howes, 2008). Wanting to help can lead to unrealistic expectations of themselves and reluctance to recognise their own limitations and vulnerabilities (Theriault, 2003). Undertaking work that leaves the therapist feeling ‘out of their depth’, albeit with good intentions, can be harmful to the client as they are not getting the quality of care required and also to the therapist as feelings of incompetence can lead to burnout (Theriault, 2003). Some participants reported that clients with a diagnosis of Post-Traumatic Stress Disorder (PTSD) were *“much more riskier”* (Beth) and they worried about *“getting it right”* (Beth). However, even though they felt challenged, they reported continuing their work with the clients due to feeling an expectation to do so. It would appear that these expectations may come from themselves, the client, or in some cases the agencies.

Working pre-trial with clients who have been sexually assaulted brings complexities that therapists do not face in other situations. These include, an awareness of the legal implications of their work, maintaining the different ethical priorities of court and helping clients with the varying needs they present with (Bond and Sandhu, 2005; Mitchels, 2016). The participants interviewed in this study, stated they had noticed a rise in clients being referred with a diagnosis of Post-Traumatic Stress Disorder (PTSD). It is also worth noting that a client can present with the symptoms of PTSD without having a diagnosis, as PTSD can go undiagnosed in many cases as not all health professionals have appropriate training to diagnose the condition (Riddle, 2018). Research has indicated that 60% of victims of rape and sexual assault develop PTSD (Smith and Heke, 2010), suggesting that therapists working in the field of sexual assault are highly likely to see clients presenting with symptoms

associated with PTSD either with or without a clinical diagnosis. However, as the condition may go undiagnosed, the therapist may not be aware of the extent of the complexities the client is presenting with until they have begun the work. This was the case with Rachel who found after starting work with her client, that she was *"suffering with complex PTSD".* In this instance, Rachel was able to refer the client to another therapist for Eye Movement Desensitisation and Reprocessing (EMDR) as Rachel realised this was outside the level of her competency, and there was somewhere appropriate to refer the client on to. However, in some services or areas, alternative referral routes may not be available, which may put added pressure on the therapists to keep working with a client.

The symptoms of PTSD include re-experiencing of the traumatic event, hyper-vigilance, negative moods, avoidance, fear, shame, dissociation and a negative self-perception, leaving the person to feel defeated and worthless, which are extremely challenging for therapists to work with and require a particular skill set (Andrews, Brewin, Rose, and Kirk, 2000; DSM-5, 2013; NICE, 2018; Talbot, Talbot, and Tu, 2004). The National Institute of Clinical Excellence (NICE, 2005) guidelines recommend that individuals who are exhibiting symptoms of PTSD three months after the trauma, should be offered Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) or EMDR as recognised evidence-based treatment models for PTSD. Four of the participants interviewed in this study reported to have furthered their professional development by gaining knowledge of stabilisation techniques to use when working with clients with PTSD. However, this did not appear to be a requirement of the agencies they were employed by, and only one participant was trained in a NICE recommended therapy (EMDR). The stabilisation techniques may be all that would be approved by the current CPS (2001) guidelines, however, therapy is offered by the agencies and private practitioners post trial, therefore it could be argued that

training in a NICE (2005) recommended treatment model for symptoms of PTSD may be a necessary requirement for all therapists working with sexual abuse. This then raises the question as to whose responsibility is it to ensure that therapists have the appropriate training in working with clients' pre-trial and in treatment models for symptoms of PTSD. Does it lie solely with the therapist and their supervisor, or do the CPS, NICE, sexual assault agencies and even professional bodies such as the BACP and BPS, have an ethical responsibility to clients to ensure the therapist they are working with has appropriate training to keep them safe and provide the quality of treatment they require. This is especially important when considering the revised NICE (2018) guidelines that state practitioners working in this area should have *"training and competence in delivering interventions for PTSD"* (p.23).

The debilitating symptoms associated with PTSD bring up the dilemma as to whether it is morally acceptable to withhold treatment that may alleviate these extremely distressing symptoms. Another sub-ordinate theme that emerged from the data was the concern therapists had relating to whether the client's well-being or the outcome of the criminal proceedings was of greater importance. James expressed his opinion that it was *"unethical"* to withhold treatment that was available and evidence-based for purely legal reasons and said he would give his client the choice as to whether or not they wanted to wait until after the trial to receive treatment. In fact, the revised NICE, (2018) guidelines state *"do not delay or withhold treatment for PTSD solely because of court proceedings"* (p.10), and recommend that clients make informed decisions after discussing all implications with their therapist. However, a further concern is that if a client decided to delay treatment for fear it would result in the trial being abandoned, and was meanwhile suffering from the very debilitating psychological impact of PTSD, the question remains as to how reliable a witness they would be. A person who is experiencing the symptoms of PTSD would find it

extremely difficult to organise the details of the traumatic incident they experienced into a coherent account, as in some cases they are unable to recall the sequence of events or they may miss vital details (van der Kolk, 2014). The trauma of the incident can affect how the event is remembered, for example, research into the 'weapon focus effect' demonstrates how the presence of a weapon may leave the victim focusing on that, leaving them unable to remember other vital details such as what the person holding the weapon looked like (Carlson, Dias, Weatherford and Carlson, 2017). Another common feature of PTSD is dissociation, which may leave the person unable to integrate the details of the event into their conscious memory, thus resulting in fragmented memories (Lanius and Hopper, 2008). These examples of research into the fallibility of memory after a traumatic experience have been well replicated, and indicate that there is an argument to be made that in *not* allowing a victim of crime to receive appropriate treatment for their trauma, that their memory of the event may remain fragmented and disjointed.

Neuroscience has also shown that in brain scans of people experiencing flashbacks, a symptom of PTSD, the Broca area of the brain, responsible for speech, goes offline leaving the person unable to put their thoughts and feelings into words (van der Kolk, 2014). However, the police and the criminal justice system expect the witness, suffering with the psychological impact of PTSD, to provide a detailed, chronological, coherent and consistent account of the incident, although empirical evidence clearly shows that this may not be possible (Smith and Heke, 2010). Therefore, it could be argued, that encouraging the witness to have treatment prior to the trial would be beneficial to the criminal proceedings as the processing that they have had an opportunity to engage in, can help them to contextualise the trauma and enable them to give a more accurate and comprehensive narrative of the event in court (McLeod et al. 2010). Hence, there may be potential value to the court proceedings of

allowing (or even encouraging) a victim to undergo appropriate evidence-based trauma-specific therapy prior to being required to take the stand as a witness. If this suggestion were to be taken seriously, it may then be possible to find a way to bridge the gap between what is currently recommended in the CPS (2001) guidance and the therapeutic support available to traumatised, vulnerable or intimidated witnesses.

Although there is good evidence for encouraging pre-trial trauma-related therapy, a key argument against it has stemmed from debates predominantly in the 1980s and 1990s regarding worries about therapists creating 'false memories'. This idea quickly captured the attention of the general public, as well as the courts, and may have been a key factor that influenced the CPS decisions in 2001 regarding therapy for vulnerable or intimidated witnesses. At the time that these debates were rife, there were claims by some parents and the church that the alleged victims of childhood abuse were making these accusations following false memories that were 'implanted' in victims' minds by therapists (Jenkins, 2002; van der Kolk, 2014). However, there is an abundance of scientific evidence to support the fact that trauma memories can be repressed and resurface years later (van der Kolk, 2014). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) also recognises dissociative amnesia as a condition linked to PTSD leaving the person unable to recall autobiographical information. Therefore, rather than being 'implanted' there is also a strong case to be made, that so called 'false memories' could just as easily be understood as *recovered* memories.

In 1995 The British Psychological Society investigated allegations against therapists inadvertently implanting false memories into victims claiming to have been abused in childhood, but stated they found no evidence to support the claim (Jenkins, 2002). The false memory debate appears to be an area that continues to be investigated, however, there is evidence that repression and dissociation resulting in memory loss

is linked to stress (Brewin and Andrews, 2017). Brewin and Andrews (2017) found from their experiences in court that it was rare for therapists to set out to recover memories of abuse and that many recovered memories first emerged prior to the commencement of therapy. This may suggest that if the 'false memory debate' was an influence to the CPS when considering how therapists work with clients pre-trial, their views about how 'discussions' in therapy may be considered as 'coaching' witnesses', could be argued to be based on out-dated data and not necessarily in agreement with current research.

Many of these concerns could be grouped under an overarching rubric of 'ethical issues'. In fact one of the key super-ordinate themes that emerged from the inductive analysis of the data, was the participants' concern over ethical issues. Examples were that participants were worried they were in effect 'silencing the clients' by not allowing them to talk about the actual abuse. Another example was participants' dilemmas about what details to write in their session notes. The fear of any discussion relating to the event being seen as 'coaching' the client and possibly jeopardising the court case, meant that in some instances participants felt they were 'silencing' clients. Participants struggled with the ethicality of this as it felt like they were *"repeating the abuse"* (Susie) and that in enforcing silencing on their clients, may be *"potentially deeply traumatising"* (James). Cathy described it as a *"big ethical dilemma"* as it went against the British Association for Counselling and Psychotherapy (BACP) ethical framework that she worked under, stating the beneficence and autonomy of the client is paramount (BACP, 2018). The CPS (2001) guidelines state that discussions around the evidence given by the witness *"may lead to allegations of coaching and, ultimately, the failure of the criminal case"* (p. 5). However, there is some ambiguity here as the CPS (2001) guidelines also state *"while some forms of therapy may undermine the evidence given by the witness, this*

will not automatically be the case" (p. 7). Indeed, in the case of James, he had worked with his client prior to the reporting of the offence, and had used Eye Movement Desensitisation and Reprocessing (EMDR). This is a treatment model that may be viewed by the CPS as 'recounting' memories as EMDR facilitates the processing of traumatic memories (Shapiro, 2001). However, the use of this technique was not challenged in court. The CPS guidance therefore could be argued to be ambiguous on the matter of not giving clear direction as to what modality of pre-trial therapy can be safely undertaken, leaving a grey area regarding what methods of therapy are least likely to prejudice the evidence (Mitchels, 2016).

The participants interviewed reported being aware the session notes they wrote were likely to be subpoenaed by court. Within the agency settings this was discussed with the client at the initial stage of contracting, and the client was informed of the limitations of confidentiality and were asked to read and sign a record of their notes. Susie spoke about the counsellors in her agency being trained to write their notes with the courts in mind. This may not be the case for therapists who do not work for an agency, and decisions about what should or shouldn't be included in session notes for pre-trial clients may be more complex than normal requirements. Therapists therefore need to be aware of their own professional body's guidance, the current laws and the CPS (2001) guidance in relation to recording and sharing information whether in private practice or within an agency, so they are able to inform clients of the limits to confidentiality (Mitchels, 2016).

A survey was carried out by a Sexual Assault Centre of 35 practitioners attending a pre-trial therapy conference on their experiences of working with clients' pre-trial. Results indicated that there was divided opinion among practitioners in relation to their obligations when requested to release client notes, which suggested there was confusion about their procedural and legal responsibilities (Jenkins, Muccio and

Paris, 2015). The CPS (2001) guidance states that records will only be expected to be released in compliance with a court order, due to the therapist's duty of confidentiality to their clients. Susie was concerned about what to include in her notes as she feared if the client mentioned the incident that may jeopardise the court case. The BACP (2018) ethical framework requests that notes are *"adequate, relevant and limited to what is necessary"* (p.14). However, legally all material that may be relevant to the case needs to be recorded, such as: who was present, dates, times, quotations of client wording and other significant comments and by whom, and the records need to be kept up-to-date and should not be destroyed while criminal proceedings are pending (Hamilton, 2014; Mitchels, 2018). Thus there may be conflicting messages from different professional bodies about what should be recorded. Additionally it is argued that for the sake of confirming accuracy, therapists should check information recorded with the client before the details are committed to the notes (Mitchels, 2018).

Another sub-ordinate theme that emerged from the analysis of the data was a lack of clarity between other professionals in relation to the CPS guidance. Participants reported that professionals, including victim care workers and the police were giving out *"wrong information"* (Janet) and informing clients they were not allowed to have therapy because their case *"was going to court"* (Susie). Therapists reported that identification of the need for therapy in adult witnesses by many professionals can be very poor, and witness care officers and police offices are still apprehensive about referring a witness for pre-trial therapy (Mitchels, 2016). An example of research specifically in this area is by Plotnikoff and Woolfson (2004) who carried out a study of 50 young witnesses' experience of the criminal justice system. Results indicated that they and their families were advised that therapy could not take place until after the court proceedings, as police officers were unaware of the CPS recommendations

regarding pre-trial therapy (Jenkins, 2013). The implication that some police officers are uninformed about CPS guidance is a major concern considering research has shown that pre-trial therapy can assist the witness in their recovery, and delaying therapy means an unnecessary extension of suffering that, in some cases, has led to depression and suicide (McLeod et al. 2010; Mitchels, 2016).

The participants' concern over lack of clarity between professionals extended further to the court proceedings. In particular, some of the participants were worried that jurors were uneducated as to the psychological impact of trauma such as *"tonic immobility"* (Susie) and that members of the jury may have their own *"baggage"* (Susie) about sexual abuse. An example of research in this area is by Ellison and Munroe (2009) who carried out a study using 'mock jurors' to ascertain whether jurors were able to make informed, accurate and credible decisions in rape / sexual assault cases without receiving additional guidance. The study focused on jurors' understanding of victims' reactions in three main areas; delayed reporting, no physical injury and calm demeanour (Ellison and Munroe, 2009). Ellison and Munroe (2009) found that the 'mock jurors' had limited understanding of the psychological responses to rape / sexual assault and common reactions were outside of the average jurors experience and knowledge. This resulted in them drawing negative conclusions if victims were not distressed or hadn't fought back or delayed reporting the offence, which may relate to social 'myths and stereotypes' of how victims should respond (Ellison and Munroe, 2009). However, when 'mock jurors' were presented with an expert testimony providing neutral information on relevant research into psychological response to trauma, it enabled them to more accurately profile the victim when deliberating whether the defendant was guilty or not guilty (Ellison and Munroe, 2009). Therefore, the Ellison and Munroe (2009) study suggests a strong

possibility that without educational guidance jurors may make decisions based on potentially inaccurate prior assumptions and biases.

Summary and Recommendations

There appears a number of ethical issues have been raised in this study. The issue of competency is a serious concern, and it is worth noting that in most cases the therapists' desire is to help their clients, and it is not their intention to be drawn into working outside their level of competency (Theriault, 2003). However, this study has shown that in some cases, the extent of complexity presented by clients may have gone undiagnosed, meaning the therapist is unaware of all symptoms until after the work has commenced. All of the participants interviewed agreed about the importance of attending regular supervision due to the complexities of their cases. Supervision provides therapists with an opportunity to reflect on the impact of their work and ensure clients are receiving the quality of treatment required (BPS, 2018), and also gives the therapist opportunity to identify professional development needs to ensure good practice (BPS, 2018). Considering the array of issues presenting in working pre-trial with victims of sexual assault, which may not normally be faced in other therapeutic situations, it would seem imperative that the therapist and supervisor have specific training in pre-trial therapy. Indeed, CPS (2001) guidelines state that therapists working with vulnerable or intimidated witnesses pre-trial need to be appropriately trained and supervised.

There are clearly additional requirements when working with a client pre-trial, including a knowledge of criminal proceedings, awareness of the legal implications of the work, the ethical requirements of their professional code of conduct, and the responsibility of helping the clients who, empirical evidence suggests a high

percentage will present with symptoms of PTSD (Bond and Sandhu, 2005; Mitchels, 2016; Smith and Heke, 2010). However, at present there is not a central register available of therapists that are qualified to provide pre-trial therapy. This may be due to the varying skills and knowledge that would be required (Mitchels, 2016), but arguably, this would be exactly why such a register is necessary and could be seen as an ethical responsibility to the client. This may be challenging task, however, appropriate organisations may be able to work collaboratively to decide the appropriate level of training required, and to consider how that may be delivered and by whom.

Another ethical concern reported by some therapists was the possible consequences of jeopardising the court case if the client spoke about the offence and the dilemma of withholding treatment from clients who were suffering with the debilitating symptoms of PTSD. The CPS guidelines were written in 2001, approximately 17 years ago, and relied heavily on expert witness opinions based on the therapeutic models that were available at that time, in comparison with the contemporary evidence-based practice approach adopted by NICE (2018) (Jenkins, 2013; Mitchels, 2018). Empirical research suggests that a person suffering with the symptoms of PTSD would find it very difficult to give a coherent narrative of the traumatic incident, with their memories likely to be fragmented and disorganised. This may possibly indicate, they would be less likely to be a reliable witness without receiving appropriate treatment for their trauma. Since the CPS guidelines were developed there have also been new developments in psychotherapeutic practice and new therapeutic techniques and modalities have emerged (Mitchels, 2018). For instance, EMDR is an evidence-based treatment for PTSD, that helps clients process trauma memories, arguably then, enabling them to provide a more accurate and comprehensive account of the incident. This technique actually, involves very little

verbal input from the therapist and the client does not need to talk in detail about the trauma to heal (van der Kolk, 2014). So, arguably, it could be said that as there is very little dialogue between the therapist and client, it could not be perceived as 'coaching' the witness. It is suggested that further research is required into the fallibility of memory after a traumatic incident and whether the memory of the incident has improved after they have undergone an appropriate evidence-based trauma-specific therapy.

The Ministry of Justice report (MOJ, 2014) and the CPS 'Violence Against Women and Girls' report (2015-16) recognised the need for improvement by the criminal justice systems' in relation to rape and sexual assault cases and have identified reforms that needed to be considered and have put forward various recommendations. The CPS are clearly working with the police and Counsel to change the myths and stereotypical views that have historically been attached to victims of rape and sexual assault by providing training on the subject (CPS, 2015). The police updated their Authorised Professional Practice (APP) on rape in conjunction with the CPS in 2016 and they have developed a police training programme to coincide with this (CPS, 2015-16). However, dispelling the myths, although an ongoing process, within the criminal justice system, does not include educating the jurors. Ellison and Munroe (2009) discovered that jurors had limited understanding of typical psychological responses to rape, and were unable to make accurate and informed decisions without the educational guidance of expert testimony on the psychological impact of trauma. A means of addressing these inherent predisposed biases or assumptions (Ellison and Munroe, 2009) may therefore be to ensure jurors are educated in rape and sexual assault cases as well as the Counsel.

This research is one of the first qualitative studies to explore the lived experience of therapists working pre-trial with the CPS guidelines with adult clients who have reported sexual assault in the United Kingdom. It is acknowledged that in order to carry out an in-depth study, a small sample size of UK based therapists were interviewed, and perhaps the findings may not be as transferable to other parts of the world, or to other services. However it is hoped that this study will encourage further research of this kind to be replicated in other countries and settings.

Chapter 5

Conclusion

Involvement in criminal proceedings for vulnerable or intimidated adult witnesses of rape or sexual assault is an extremely emotional and stressful process (Herman, 2003). The agenda to protect the mental health of the witness can often be at odds with what is required from them in legal proceedings, and witnesses who have gone through the criminal proceedings have described the experience as a 're-victimisation' (Herman, 2003). The Crown Prosecution Service (CPS) recognised the need for vulnerable or intimidated witnesses to receive therapy prior to trial, and is why the guidelines were written in 2001. However, since the guidelines were produced there has been considerable research into the reliability of the 'false memory' debate in the 1980s and 1990s, and there has been extensive research into the fallibility of memory following a traumatic experience (Jenkins, 2002; van der Kolk, 2014). Since 2001 there has also been extensive developments in counselling and psychotherapy and new therapeutic techniques and modalities have emerged (Mitchels, 2018). In fact, taking into consideration recent research into the debilitating psychological impact of Post-Traumatic Stress Disorder (PTSD) and the extensive developments in therapeutic techniques and modalities it could be argued that pre-trial therapy (PTT) could raise the credibility of the witness. Given the recent research and developments in therapy, perhaps, in line with many of the other reviews the CPS are carrying out, it may be an opportune time for a review and update of their current guidelines into the provision of therapy for vulnerable or intimidated adults prior to a criminal trial. A review of the current CPS guidelines may also provide more clarity to therapists about the types of therapies that could be administered and alleviate some of the ethical issues they currently experience.

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Appendices

Appendix 1

Email to service managers of sexual abuse services

Dear Sir/Madam

Re: MSc Research Study: 'What is the lived experience of therapists' working pre-trial within the Crown Prosecution Service Guidelines with adult clients who have reported sexual assault?'

My name is Madelyn Nixon and I am currently in my final year of studying a Master of Science (MSc) degree in Therapeutic Practice for Psychological Trauma at Chester University. In order for me to achieve my MSc I am required to undertake a dissertation, the title of which is stated above.

I am a psychotherapist with a private practice and I also work for an agency that service clients that have been sexually abused in childhood. In both settings I work with clients who have been raped or sexually abused, some of which have reported the offence and so I have worked with them pre-trial within the Crown Prosecution Service (CPS) guidelines. My experience has led to my interest in this study and I would like to gain the views and experiences of other therapists that work in the sexual abuse field. I am specifically interested in their experiences, thoughts and feelings of working pre-trial within the CPS guidelines.

The dissertation is an Interpretative Phenomenological Analysis of the therapists' experience and it requires my interviewing 4 to 6 therapists' (counsellors, psychotherapists or psychologists) for approximately 45 – 60 minutes. I am requesting that you email the attached letter to the therapists' working in your organisation, which will give details of the research study and invite them to participate.

The research will be conducted in accordance with the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice, the University's Research Governance Handbook and has been approved by the Research Ethics Committee at the University of Chester, Department of Social and Political Science.

The identifying details of participants will only be known to me and any identifiable information will be removed or changed and a pseudonym will be used for information relating to participants in the writing up of the dissertation.

I would be grateful if you could inform me of your decision as to whether you agree to send the attached letter to the therapists you employ.

If you require any further information, or if there is anything you would like to discuss further, please do not hesitate to contact me on (Telephone number was supplied of a mobile phone specifically purchased for the research study).

Thank you for taking the time to read this email and for considering my request.

Kind regards

Madelyn Nixon

Appendix 2

Letter to potential participants

Dear Colleague

My name is Maddie Nixon and I am currently in my final year of studying a Master of Science (MSc) degree in Therapeutic Practice for Psychological Trauma at Chester University. In order for me to achieve my MSc I am required to undertake a dissertation, the title of which is stated below:

'What is the lived experience of therapists who are working pre-trial, within the Crown Prosecution Service guidelines, with adult clients who have reported sexual assault?'

I am a counsellor and psychotherapist and have worked for the past seven years with child abuse and sexual assault which has led me to want to learn more about psychological trauma and has, in turn, led to my interest in other therapists' experience of working in the field of sexual abuse. I would like to hear your experiences and reflections on working with this client group alongside the CPS guidelines.

If you would like to express an interest in taking part in this research project, please contact me directly (contacting me directly and not via others will not compromise your anonymity), by email at *********@chester.ac.uk or by phone on **********. I will then forward a participant information sheet which will include full details of the research study. If you are still interested in taking part in the study, I will then contact you by telephone to clarify any questions you may have or any queries relating to the information sheet and confirm you meet the inclusion criteria. We will then arrange a mutually convenient time and venue to meet and conduct the interview.

I would like to thank you for taking the time to read this information and I hope you will consider taking part in this research project.

Many thanks

Maddie Nixon

Appendix 3

Participants Information Sheet

What is the lived experience of therapists who are working pre-trial, within the Crown Prosecution Service (CPS) guidelines, with adult clients who have reported sexual assault?

Rationale of the research

Clients who have experienced rape and sexual assault are known to have high prevalence rates of post-traumatic stress disorder (PTSD). The National Institute for Health and Care Excellence (NICE) give clear guidelines of what they recommend for treating PTSD and the Crown Prosecution Service (CPS) give clear guidelines on what a witness is recommended to concentrate on and avoid during therapy prior to giving evidence in court. There appears to be limited research into therapists' experience of working with CPS guidelines in a pre-trial context.

About me

I am in my final year at Chester University studying for an MSc in Therapeutic Practice for Psychological Trauma. I am a counsellor and psychotherapist and have worked for the past seven years with child abuse and sexual assault which has led me to want to learn more about psychological trauma and has, in turn, led to my interest in other therapists' experience of working in the field of sexual abuse. I would like to hear your experiences and reflections on working with this client group alongside the CPS guidelines.

What does participating in the research mean?

If you meet the inclusion criteria (see below) and agree to participate in the research, your involvement would be a 45 minute to 1 hour interview that will be audio recorded and explore your experiences. Prior to the interview we will spend 10 – 20 minutes ensuring you are clear on all the information provided and to answer any questions you may have. I will also ask some questions about your wellbeing, to ensure you feel safe to take part in the study. The interview will be held at a mutually convenient, safe and confidential location.

What are the potential risks of participating?

I am aware that recounting some of these past experiences may cause distress by triggering your own traumatic memories or bring up painful feelings when revisiting the client work. This is why I have asked in my inclusion criteria that you will agree to discuss with your supervisor any issues that may arise. You are also able to pause or stop the interview at any time. I have provided an information sheet that gives details of organisations that are available if you need to talk, such as, Samaritans and I have given the BACP and Counselling Directory website from which you are able to obtain list of registered therapists in your area. Unfortunately, I am not able to fund the cost of supervision or private therapy.

What are the potential benefits of participating in the research?

Participating in the research will give you the opportunity to reflect on your own experiences and potentially gain a deeper understanding on how you create meaning from your experience. It is hoped that the anonymised findings of the research will be published in a general article. This information could potentially inform other therapists working within the field of sexual abuse and other professionals, such as, the CPS and the Police.

What about confidentiality?

Throughout the research your identity will only be known by me and any identifiable information will be removed or changed and a pseudonym will be used for information relating to you in the writing up of the dissertation. The interview audio-

recordings will only be heard by me and possibly my supervisor, but no one else will have access to them. They will be stored in a password protected file on the computer and the original recording will be deleted. The transcripts will be anonymised and will be seen by me, my supervisor and external examiner. Anonymised quotes may be used in the dissertation and published material. Information provided will remain confidential unless doing so involves a serious risk of harm to yourself, another, would mean breaking the law or breaches the children or adult safeguarding policies, The Terrorism Act (2000) or The Drug Trafficking Act (1986).

Can I take part in the study?

If you meet the following inclusion criteria, I would welcome your participation in the study:

- You will need to be qualified practising counsellors, psychotherapists or psychologists to a minimum of diploma level.
- You will need to have at least one years' experience of working with survivors of sexual violence.
- You will need to have worked with at least one client pre-trial within the CPS guidelines who have reported sexual assault.
- You will have regular clinical supervision and agree to discuss with your supervisor any issues that may arise from the interview.

What may exclude you?

- Therapists who have experienced their own trauma within the last year.
- Therapists who are undergoing therapy due to a traumatic experience or significant levels of distress.
- Therapists who are not currently working due to their level of distress.
- Therapists who have experienced vicarious trauma, burnout or compassion fatigue in the last year.
- Therapists who are employed by the NHS.
- Participants not sufficiently fluent in English, as I only speak English and funds are not available for interpreters.

What if I change my mind and want to withdraw from the study?

You will be able to pause or withdraw from the interview at any time and you can also ask for part of the data to be withdrawn. You are able to completely withdraw from the research up until the point where the transcripts would be written up for the research and it would not be possible to replace your participation.

What will happen to the results?

The dissertation for my MSc will contain the results of the research and will be submitted to Chester University, who will keep a hard copy and an electronic copy. The results may also form part of other works which are put forward for publication.

What will happen to my information?

I will adhere to the Data Protection Act 1998 and The University of Chester Research Governance. The interviews will be recorded onto a digital recorder and then transferred to a password protected file on my computer. The digital recordings will be kept securely when not in use. The saved files of the transcripts of the recordings will be kept under a pseudonym. Access to my computer is password protected. A back up copy of the files will be held on a memory stick, which will be kept in a locked drawer. All hard copies of the transcripts will be kept in a locked drawer.

Ethics

The proposal for this research has been approved by the Research Ethics Committee at the University of Chester, Department of Social and Political Science. It will be conducted in accordance with the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice and the University's Research Governance Handbook. Every effort will be made to protect my participants from harm and I will be working with a research supervisor throughout this process to seek advice and guidance on any ethical issues raised.

Complaints procedure

For any complaints or adverse events contact, in the first instance, my supervisor ********@chester.ac.uk, or alternatively, **********, Professor ********** at Department of Social Studies and Counselling, University of Chester, Parkgate Road, Chester, CH1 4BJ or email: **********@chester.ac.uk. In accordance with the University of Chester Research Governance Handbook (2014), in the unlikely event that a participant is harmed by taking part in the research, there are no special compensation arrangements.

Contact details

If you would like to express an interest in taking part in this research project or have any queries relating to this information sheet, please contact me directly as responding to others will compromise your anonymity, by email: *******@chester.ac.uk or my supervisor, Dr ********** email: ********@chester.ac.uk. I will then contact you by telephone to clarify any questions you may have and confirm you meet the inclusion criteria and if you still wish to participate, we will arrange a mutually convenient time and venue to meet and conduct the interview.

Many thanks for taking the time to read this information sheet.

Maddie Nixon

Appendix 4

Email to colleagues

Dear

Re: MSc Research Study: 'What is the lived experience of therapists who are working pre-trial, within the Crown Prosecution Service guidelines, with adult clients who have reported sexual assault?'

I am currently in my final year of studying a Master of Science (MSc) degree in Therapeutic Practice for Psychological Trauma at Chester University. In order for me to achieve my MSc I am required to undertake a dissertation, the title of which is stated above.

As some of you may know, as a psychotherapist I work predominantly with trauma and specifically with clients who have been sexually abused, some of whom have reported the offence and I have worked with pre-trial in accordance with the Crown Prosecution Service (CPS) guidelines. This has led to my interest in carrying out this research and wanting to hear other therapists' experiences of this process.

The dissertation is an Interpretative Phenomenological Analysis of the therapists' experience and it requires my interviewing 3 to 6 therapists' (counsellors, psychotherapists or psychologists) for approximately 45 – 60 minutes. I am requesting your help in recruiting the participants and ask that you email the attached letter inviting participation to other therapists' in your network. Potential participants should contact me directly to ensure anonymity.

The research will be conducted in accordance with the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice, the University's Research Governance Handbook and has been approved by the Research Ethics Committee at the University of Chester, Department of Social and Political Science.

The identifying details of participants will only be known to me and any identifiable information will be removed or changed and a pseudonym will be used for information relating to participants in the writing up of the dissertation.

If you require any further information, or if there is anything you would like to discuss further, please do not hesitate to contact me by email at ********@chester.ac.uk or by telephone on ********** or my supervisor, ********** at **********@chester.ac.uk.

Thank you for taking the time to read this email and for considering my request.

Many thanks

Maddie Nixon

Appendix 5

INFORMED CONSENT FORM

Research Study Title: What is the lived experience of therapists who have been or who are currently working pre-trial with adult clients who have reported sexual assault, within the Crown Prosecution Service (CPS) guidelines?

(Please tick to confirm you have read the following)

☐ I _____ have read and understood the participant information sheet provided and confirm that I have been given adequate information about the above study and what commitment is required of me.

☐ I confirm that I meet all the requirements as specified in the inclusion criteria on the information sheet.

☐ I have had the opportunity to ask questions and I am aware that I am able to contact the researcher for any further information I may require.

☐ I agree to participate in the above named research and understand that my consent is voluntary.

☐ I understand the interviews will be recorded, transcripts will be written and anonymised quotes may be used in the study and any published material. I am aware that I am able to stop or pause the interview at any time and that I can withdraw part or all of my personal participation at any time prior to the 1st April 2018.

☐ I understand that my identity will be known only by the researcher and any identifiable information will be removed or changed and a pseudonym will be used for the information I have contributed to the research.

☐ I agree to maintain the anonymity of third party persons (e.g. clients, their families or other professionals, etc.) during the research, by not sharing any identifying details, such as, names, etc. with the researcher.

☐ I understand that in accordance with the University of Chester Research Governance Handbook (2014), in the unlikely event that a participant is harmed by taking part in the research, there are no special compensation arrangements.

Printed name of participant: _____

Signature of participant: _____

Date: _____

Appendix 6

What is the lived experience of therapists who are working pre-trial, within the Crown Prosecution Service (CPS) guidelines, with adult clients who have reported sexual assault?

INTERVIEW SCHEDULE

- Provide participant with refreshments.
- Welcome participant and thank them for agreeing to take part in the research.
- Introduce myself and remind the participant of the research question and aims of the research. Explain to participants that the aim is for them to tell their own stories in their own words. There are no right or wrong answers, I am interested in them and their experiences. Some of my questions may seem self-evident, but I want to know how you understand things, your thoughts and feelings. Please do feel free to take your time in thinking and talking.
- Remind participants that the interview will be recorded and show the participant the recording equipment, which will then be placed discreetly, but in a convenient position to record the interview.
- Turn on the recording equipment.
- Provide the participant with another copy of the participant information sheet, confirm they have read this and ask if they have any questions relating to the information provided.
- Read the consent form, ask the participant if they have any questions and if they are still happy to participate and sign the form. Give them a copy of the form.

- Remind the participant that the study will be anonymised and that a pseudonym will be used when transcribing the recording.
- Ask that they do not share personal details of clients they may discuss.
- Inform participants that they are able to pause the interview if they wish, or choose not to answer a question and that they may leave the room at any time. Remind participants that they are able to completely withdraw from the research up until the 1st April 2018, after which the transcripts will be written into the research and it will not be possible to replace your participation.

Research question:

What is the lived experience of therapists who have been or who are currently working pre-trial with adult clients who have reported sexual assault, with regard to the Crown Prosecution Service (CPS) guidelines?

Interview questions:	**Prompts:**
1. How long have you been working pre-trial, with adult clients who have reported sexual assault? 2. Can you tell me about your work with clients who have been sexually assaulted and give some examples of these experiences please?	Can you tell me more about that? Could you describe that in more detail for me please? How did you feel when …….? What was that experience like for you? Can you explain what you mean …….? What were you thinking when that happened? Have you experienced this before? What was your understanding of this? Can you tell me more about that?

3. How many clients also have a PTSD diagnosis? 4. What is your understanding of the recommended treatment approaches and timeframes for working with PTSD? 5. What is your understanding of the CPS guidance working with client's pre-trial? 6. How do you feel about the CPS guidelines stating "the witness should not discuss or be encouraged to discuss the evidence which s/he is to give in the criminal proceedings but may receive general support to help them through the process of appearing in court?" 7. How does working with the CPS guidance influence your practice, if at all and would how you work differ when working with clients that are not pre-trial? 8. What, if any, opportunities or challenges have you experienced	Could you describe that in more detail for me please? How did you feel when …….? What was that experience like for you? Can you explain what you mean …….? What were you thinking when that happened? Have you experienced this before? What was your understanding of this?

when working with the CPS guidance? 9. Is there anything else you would like to share that you feel has not been covered?	

Closure:

Check the participant's wellbeing and ask if they require any refreshments before leaving.

Provide the participant with the list of support organisations and websites providing names of registered therapists should they require to access them.

Provide payment for any travelling costs incurred.

Appendix 7

Example of exploratory comments and emergent themes tables

		Initial Comments
Emergent themes	**Original Transcript**	**Exploratory Comments**
Impact of client's deflation from decision on her angry, disappointed, sad, deflated Questioning self and her role as therapist Questioning self and her role Not valued	I felt… (long pause)… er, angry, disappointed, sad, er, deflated. Um, what's all this therapy about? How is my client going to be when actually this has been a huge incentive to, er, look after himself properly, to keep moving and everything else? And then, well it was like, (counsellor's name) what's the point in going on? You know, what is the point of doing this when the police, the CPS and everybody's turning around to me and saying, well thank you very much but no thanks	Hesitant and long pause (I felt …er) showing enormity of how decision for cases not to go ahead impacted her – angry, disappointed, sad, er deflated (again). Questioning the therapy- questioning her role? Questioning how client is going to be after the decisions – the possibility of trial giving him incentives to look after himself, keep moving and everything else! – fear of what might now happen? Personal – asking herself what is the point of going on – questioning her role again? Everyone against her – similar to first client, when everyone against her in the court? Everyone turning around to her and saying well thank you very much but no thanks – not feeling valued?

		Initial Comments
Emergent themes	**Original Transcript**	**Exploratory Comments**
CPS guidelines CPS guidelines	There are… there are certain therapies that they actively tell you to avoid like Psychodynamic, like Hypnotherapy, um, so things like that they don't want you to go near. Um, but what you can do is… and they ideally don't want you to kind of go near the details with the person but they're very comfortable with you to talk about the impact its had on the	Certain models of therapy CPS say should be actively avoided CPS ideally don't want you to kind of go near the details with the person but they're comfortable with you talking about impact it has had on client – her understanding of PTT

Benefits of PTT CPS guidelines – benefits of PTT	person and helping them kind of in the here and now. Um, and sometimes if you've got someone as traumatised as this person that I've just was work… talked about that I was working with, actually given them a better quality of life in the here and now when you're a time-limited service is probably actually the best you can do. Um, so certainly it's… it's much more of a focus on the impact rather than what actually happened to the person, the CPS doesn't really want you to go near what happened to the person.	"actually giving them a better quality of life in the here and now when you're time limited service is probably actually the best you can do" – benefits of PTT Focus on the impact rather than what actually happened, CPS doesn't want you to go near what happened to the person - understanding of CPS guidelines

Appendix 8

List of Support Organisations and Websites with a List of Registered Therapists

Mind

Provides advice and support to empower anyone experiencing a mental health problem.

Mind Infoline: Lines are open 9am to 6pm, Monday to Friday (except for bank holidays).

0300 123 3393
info@mind.org.uk
Text: 86463

Website: http://www.mind.org.uk/

Rethink Mental Illness

Provide expert, accredited advice and information to everyone affected by mental health.

General enquiries: 0121 522 7007. Lines are open from 9am – 5pm, Monday to Friday. You can email via their website.

Website: https://www.rethink.org/

Sane

Sane is a UK mental health charity. They work to improve quality of life for anyone affected by mental illness.

Helpline: 0300 304 7000. Lines are open every day of the year from 6pm to 11pm.

Email: sanemail@org.uk

Website: http://www.sane.org.uk/

Anxiety UK

Charity providing support if you've been diagnosed with an anxiety condition.

Phone: 08444 775 774 (Mon-Fri, 9.30am-5.30pm)

Website: www.anxietyuk.org.uk

Samaritans

Confidential support for people experiencing feelings of distress or despair.

Phone: 116 123 (free 24-hour helpline)

Website: www.samaritans.org.uk

British Association for Counselling and Psychotherapy

The BACP provide a list of registered counsellors in your area.

Email: bacp@bacp.co.uk
Call: 01455 883300, phone lines are open 9am to 5pm.
Text: 01455 560606

Website: http://www.bacp.co.uk/

Counselling Directory

Confidential directory of trained, professional counsellors and therapists in the UK.

Tel: 0333 3447 990, phone lines are open from 9am to 5pm.

Website: http://www.counselling-directory.org.uk/